30234

EX·LIBRIS·COLL·MED·PHILAD·INSTIT·A·D·MDCCLXXXVII

NON SIBI SED TOTI

Class Journal No.

LIBRARY GENERAL FUNDS

Luther S. Bent
Binding Fund
William T. Carter
Catalogue Endowment
Louis A. Duhring
W. V. & J. M. Keating
Henry Leffman
Library Endowment
Morris Longstreth
Phila. Med. Society
Charles H. Vinton
Douglas Stockton Warren
J. William White
Caspar Wistar

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Digitized by the Internet Archive
in 2016

https://archive.org/details/michiganmedicine8019mich

MICHIGAN MEDICINE

January 1981 JOUR SOCIETY Vol. 80, No. 2

LIBRARY [illegible]
COLLEGE OF [illegible]
OF PHIL[illegible]

FEB 3 - 1981

1981 Maternal Health Conference

Who to call at MSMS headquarters

Advertising (in *Michigan Medicine*)	Bonnie Groff
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Arrangements	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Marce Ireland
Category I Calendar (for *Michigan Medicine*)	Bonnie Groff
MSMS-Sponsored Conferences	Sherry Fent
Dues Payments	Jerry Trahan
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Governmental Agencies Liaison	Sherry Wellman
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	John Richards
HSA Support Center	Dennis Paradis
Impaired Physicians	Marcelyn Ireland
Jail Health Project	David Schut
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
Medical Assistants	Caroline Rich
Medical Auxiliary	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Bonnie Groff
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Meredith Fors
Michigan Doctors Political Action Committee	Kevin Kelly
Michigan Medicine (MSMS Journal)	Judy Marr
Michigan Psychiatric Society	Helen Schulte
Michigan Society of Anesthesiologists	Meredith Fors
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Arrangements	Marce Ireland
MSMS News Relations	Mert Scholten
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
Physician Hospital Relations	Dick Campau
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	Bill Madigan
PSRO	Sherry Wellman
Socio-Economic Surveys	John Richards
Specialty Societies	
Information	Katie Brewbaker
Council of Specialty Societies	Bill Madigan
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society
120 West Saginaw (Box 950)
East Lansing, MI 48823

MSMS PHONE: 517/337-1351

This month's cover photo illustrates the subject of the special report beginning on page 6 of this issue: the 1981 Michigan Maternal Health Conference theme, management of the high-risk infant and its family. Rocking a newborn in the neonatal intensive care unit of E.W. Sparrow Hospital, Lansing, is Susan Burger, RN. **Photo by Mert Scholten, MSMS staff.**

MICHIGAN MEDICINE

January 1981, Volume 80, Number 2

pecial report

The hazardous course of the high-risk infant will be studied by participants at the 1981 Michigan Conference on Maternal and Perinatal Health — the 20th annual. MSMS, chief sponsor and organizer of the major scientific event, has arranged an outstanding two-day program for March 25 and 26 at the Hyatt Regency Dearborn. Speakers, topics, abstracts, program and registration form appear in this issue's special report.

Features

12 Photo highlights of 1980 MSMS Annual Scientific Meeting

14 Refugee report: The "second holocaust," DSS statistics on common diagnoses among Indochinese refugees in Michigan, mental health needs of refugees; R.J. Weiss, MD

26 Wayne County Medical Society assessing its new organization along geographic, hospital staff lines; Dwight Angell

28 MDPAC has outstanding batting average in 1980 general elections; Thomas C. Payne, MD

Departments

2 In my opinion; Vickers C. Hansen, MD

3 Letters

5 MSMS/A; Donna Chase

23 Medical newsfronts: new department

24 Views; David Siegel, MD

27 Health planning update

30 News

33 Meetings

34 Category I meetings

38 Deaths

40 Classifieds

42 President's page; John R. Ylvisaker, MD

Thanks to our advertisers

Advance Medical Research Center 34
Brown Pharmaceutical 11
Burroughs Wellcome 24, 32
Dempsey Data Service 16
I.C. System 17
Eli Lilly 29
Marion Labs 37
Medical Protective 38
Mercywood Hospital 36
Michigan Physicians Mutual Liability Company 13
Mt. Carmel Mercy Hospital 24
Physicians Insurance Company of Michigan 35
Roche 4,5,20,21,22,31,39,IBC,BC
Smith Kline & French 19
Stat Medical Books 33
Stratton Cheeseman 25

302349

JAN 19 1983

IN MY OPINION

Let's make personal commitment to offer MSMS membership to colleagues

By Vickers C. Hansen, MD, Manistee

The membership is the life blood of any organization. The constant attrition of relocation, retirement, and other events result in losses that must be offset by obtaining new members. The size of the membership is important for many reasons. Any organization that represents a constituency must have within its ranks a significant number of those individuals for whom it speaks.

We are all familiar with the contributions that the Michigan State Medical Society makes directly and indirectly to ourselves, our profession, and the people of Michigan. MSMS is involved in communications with the public and with medical care legislation. Medical education accrediting and programing are major roles. Insurance and economic programs are valuable services, as are services to impaired physicians and addressing the problems of ethics or grievances.

MSMS membership includes about 9,600 Michigan physicians. Licensed MDs and DOs are eligible to apply. Still, many physicians in Michigan are not members, for a variety of reasons. Many of the non-members are not aware of MSMS and what it does and can do for them. In many cases, this lack of information and the absence of an invitation to join may be the primary reasons for non-membership.

Membership in MSMS begins at the grass roots, with the component county society. At this level the non-members can be identified and a program developed for effective contact and recruitment.

Interest, information, and an explanation of what MSMS is and does, by an individual known to the prospect, are effective. An invitation to attend the component society meeting and functions may help the non-member appreciate the significance and importance of membership. Many don't know how MSMS is organized and the relationship of the component societies with MSMS.

In the smaller societies, the non-member may be known and identified. In the larger societies, non-members may not be recognized. Here lies the opportunity to identify and invite those individuals to join, become involved, and participate.

The personal approach, in an organized and coordinated program, by individuals in the local society, can be most effective. It is not an expensive project requiring a Madison Avenue advertising agency. If many participate, it should not require an inordinate amount of time.

All it takes is interest and commitment, on the part of the membership, to contact all individuals eligible for MSMS membership and invite them to come in, take a look, and decide for themselves.

I think we would be surprised what can be accomplished.

Doctor Hansen is a member of the MSMS Committee on Publications.

Editor's note: The MSMS Council on Dec. 3 approved a major new MSMS member recruitment program designed by the MSMS Committee on Membership Recruitment and Retention.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
James H. Tisdel, MD, Port Huron,
Chairman
Busharat Ahmad, MD, Marquette
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon

Editor
Judith Marr

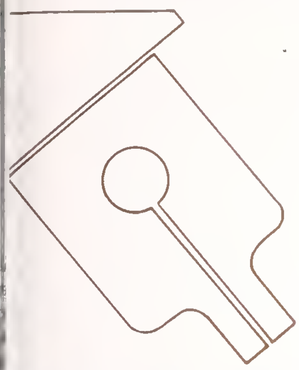
Michigan Medicine, the official journ
the Michigan State Society, is dedic
to provide useful information for Mi
gan physicians about actions of the M
igan State Medical Society and conten
rary issues, with special emphasis
socio-economics, legislation and n
about medicine in Michigan.

The Michigan State Medical Soc
Committee on Publications is the edito
board of *Michigan Medicine* and adv
the editors in the conduct and policy
the magazine, subject to the policie
the MSMS Council.

Neither the editors nor the state med
society will accept responsibility
statements made or opinions expresse
any contributor in any article or fea
published in the pages of the journal.
views expressed are those of the wr
and not necessarily official position
the society. Products and services ad
tised in *Michigan Medicine* are nei
endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-22
is the official journal of the Michi
State Medical Society, published ur
the direction of the Publications Com
tee. Published three times a month, 3
sues by the Michigan State Medical S
ety as its official journal. Second c
postage paid at East Lansing, Mich. an
additional mailing offices. Yearly s
scription rate, $15.00; single cop
$1.50. Additional postage: Canada, $1
year; Pan-American Union, $2.50
year; Foreign, $2.50 per year. Printe
USA. All communications relative to
cles, news, exchanges, advertising, sh
be addressed to Judith Marr, Mich
State Medical Society, 120 West Sagi
Street, East Lansing, Michigan 48
Phone Area Code 517, 337-1351. ©1
Michigan State Medical Society.

ETTERS



ere is summary of symptoms formaldehyde gas toxicity

uring the last year, the Michigan Department of Public Health become increasingly concerned the symptoms associated with naldehyde exposure in private ellings. The Department is writing summary of symptoms as additional background to your conration of formaldehyde in relato your patients' complaints.

Formaldehyde gas is released ler certain circumstances from a-formaldehyde foam insulation, from plywood, particle board, chipboard. Small quantities may released from rug and curtain kings, and permanent press fab-.

ute toxicity

Formaldehyde levels in comint homes in Michigan have ged from undetectable to one part million. In unsensitized persons, irritations may occur at concenions as low as 0.05 ppm; upper iratory tract irritation may occur .3 ppm. Formaldehyde is a strong tant and sensitizer, with sympis that have some similarity to se associated with colds, innza, and allergies. Formaldehyde acts as a central nervous system ressant.

Patients with formaldehyde exure typically present with the foling symptoms: irritation to the cous membranes of the nose, eyes, upper respiratory tract, nasal gestion, difficulty in breathing, rtness of breath, skin rashes, itch-, gastrointestinal disturbances, isea, dizziness, headache, and eral fatigue. Exposure may also lead to insomnia, disorientation, increased thirst, and behavior changes such as irritability, inability to concentrate, and paranoia.

In addition, there are reports of chronic nausea, vomiting, and diarrhea in infants and young children under the age of two living in homes in which formaldehyde-emitting materials have been used, such as mobile homes and foam-insulated homes.

Sensitization may develop, with resultant allergic symptoms including pruritus, dermatitis, and bronchospasm. Sensitized individuals may develop increasingly severe reactions. It is estimated that 4.5 to 7.8 percent of the population may be sensitized to formaldehyde. Skin patch testing has been effective in identifying sensitized individuals.

Chronic toxicity

Results from a long-term formaldehyde inhalation study, scheduled for release soon, show a high proportion of nasal squamous cell carcinomas in rats. Evaluation is underway to consider formaldehyde as a potential human carcinogen.

Diagnosis of formaldehyde toxicity should be considered in any patient presenting with the above symptoms and living in a mobile home, or a conventional home insulated with urea-formaldehyde foam, or any home in which extensive remodeling or new construction has taken place. Supporting evidence is the persistence of symptoms without other explanation and the alleviation of symptoms upon removal of exposure. Since there is no practical laboratory method of diagnosis, the temporal relationship of symptoms to exposure is the most crucial factor in diagnosing formaldehyde toxicity.

Definitive management of formaldehyde toxicity is based on eliminating exposure. This may be done by improved ventilation in some cases, removal of urea-formaldehyde foam or a change of residence. Chemical treatment of urea-formaldehyde foam insulation to prevent emission of formaldehyde has been tried with variable results and effectiveness has not been scientifically documented.

If a physician feels the symptoms are consistent with a diagnosis of formaldehyde toxicity and there is reason to suspect that formaldehyde exposure exists in the home, a physician may determine that testing of the home environment for formaldehyde levels is warranted. The Department of Public Health can make available on request a list of private laboratories that provide formaldehyde testing services. This list of private laboratories would not represent Department of Public Health endorsement or referral.

Consideration is being given to a proposal for a fee-supported testing program within the Department of Public Health. The nonprofit testing fee to partially defray costs would expectantly be less than the cost of private laboratory and consultant fees, and would be paid by the residents with the complaint. Under this program, Department of Public Health testing services would be performed at the request of physicians for only those cases in which symptoms and circumstances of the home environment indicate a probable formaldehyde problem.

Special risk groups

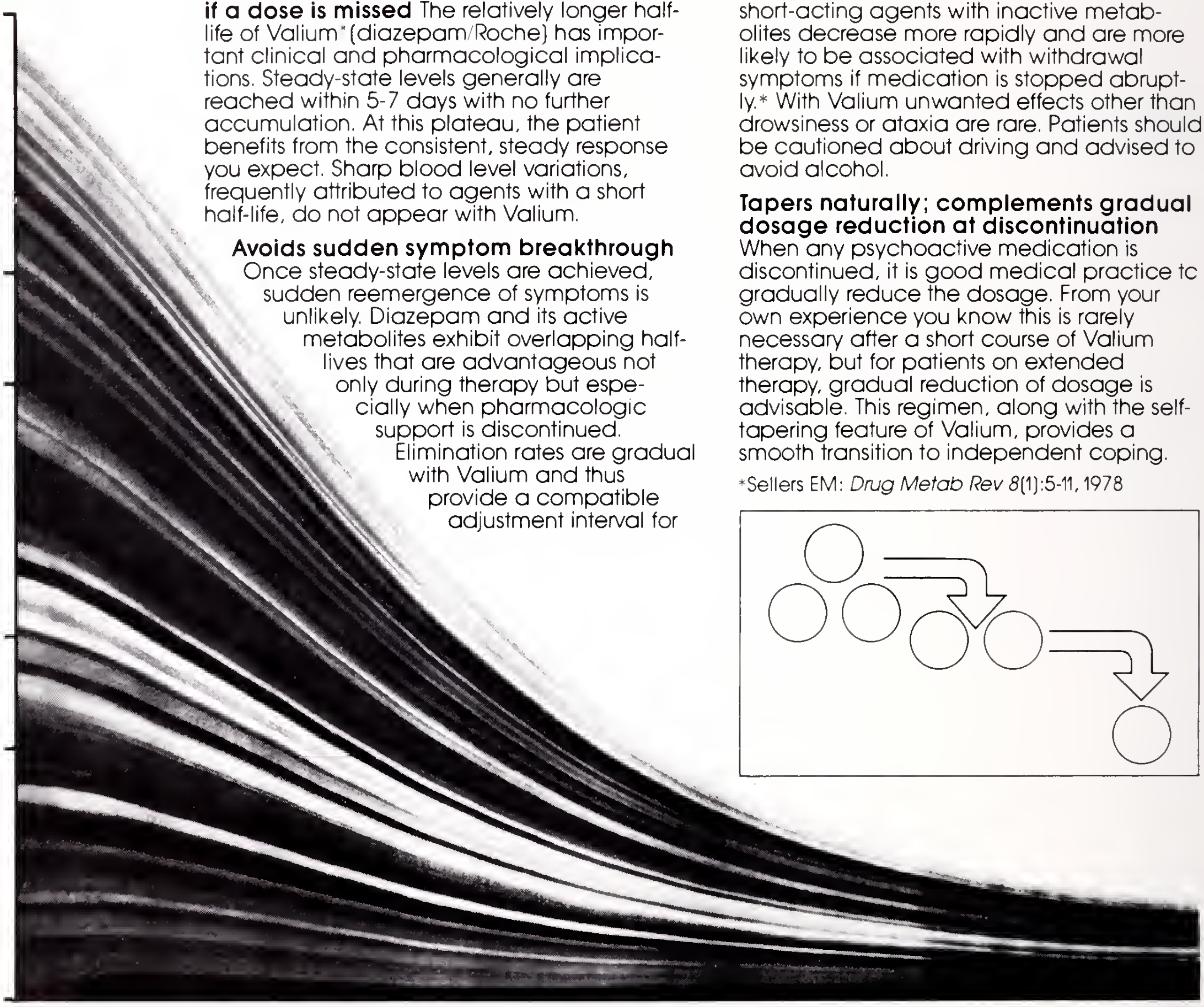
1. Elderly individuals and those with chronic respiratory disease may suffer more serious reactions.
2. In persons with a history of allergies, formaldehyde may aggrevate symptoms or precipitate new allergies.
3. Pregnant women, infants, and young children should avoid exposure to formaldehyde whenever possible.

Maurice S. Reizen, MD
Department of Public Health

more letters on page 10

half-life

Just one built-in advantage



Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978

in the management of symptoms of anxiety

Valium® Ⓘⓥ

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

effective therapy through efficient pharmacodynamics

Before prescribing, please see summary of product information on next page

ROCHE®

Valium® IV
diazepam/Roche

efore prescribing, please consult complete roduct information, a summary of which ollows:
ndications: Management of anxiety disorders, r short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium remens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm ue to reflex spasm to local pathology, spasticity aused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders not for sole therapy)
he effectiveness of Valium (diazepam/Roche) n long-term use, that is, more than 4 months, as not been assessed by systematic clinical tudies The physician should periodically reassess the usefulness of the drug for the individual atient
ontraindicated: Known hypersensitivity to he drug Children under 6 months of age cute narrow angle glaucoma, may be used n patients with open angle glaucoma who re receiving appropriate therapy
arnings: Not of value in psychotic patients aution against hazardous occupations requirng complete mental alertness When used djunctively in convulsive disorders, possibility f increase in frequency and/or severity of rand mal seizures may require increased dosge of standard anticonvulsant medication, brupt withdrawal may be associated with tempoary increase in frequency and/or severity of eizures Advise against simultaneous ingestion f alcohol and other CNS depressants Withrawal symptoms similar to those with barbituates and alcohol have been observed with brupt discontinuation, usually limited to exended use and excessive doses Infrequently, milder withdrawal symptoms have been reported ollowing abrupt discontinuation of benzodiazepines after continuous use, generally at higher herapeutic levels, for at least several months fter extended therapy, gradually taper dosage eep addiction-prone individuals under careful surveillance because of their predisposition to abituation and dependence
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully harmacology of agents employed, drugs such s phenothiazines, narcotics, barbiturates, MAO nhibitors and other antidepressants may potentiate its action Usual precautions indicated in atients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic unction Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, ypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasicity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neuropenia, jaundice, periodic blood counts and iver function tests advisable during long-term herapy

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
® Nutley, New Jersey 07110

Auxiliary members are MDs' built-in staff

By Donna Chase, Grand Rapids

Doctor, are you aware . . .

That if you are launching a public relations program or a community health project, you have a built-in staff to assist you?

Auxilians are looking for significant tasks that will benefit the medical profession. This involvement will provide a feeling of accomplishment and a better knowledge of current medical issues. Why not let your spouse help with the public relations aspect of medicine in your county?

Already, Auxilians in Genesee County are helping to staff a "hot line" to answer questions, as part of a campaign to reduce teenage pregnancy. Saginaw Auxilians are actively involved in taking "A Child's Introduction to the Hospital" to children in grades 3 and 4 in local schools. This slide presentation acquaints children with hospital procedures.

Kent County Auxilians are busy helping physicians clean their offices of unwanted and unused pharmaceuticals for World Wide Medical Relief. This involves 70 Auxilians for several days of intensive work, benefits the physician, and provides medical relief around the world.

Other valuable projects include the "Is He Sick?" pamphlet, written, produced, and distributed by Muskegon County Auxilians. Shiawassee County auxiliary members work directly with the dietary department on the Meals-On-Wheels project in their county.

A small county auxiliary membership need not deter your project efforts. The Newaygo auxiliary has eight members that organize the blood mobile program for the entire county.

Auxilians all around the State are serving physicians and their profession by building better public relations through services to the community.

With the help of this built-in staff, consider what your county medical society and its auxiliary can accomplish together!

Mrs. Chase is president of the MSMS Auxiliary.

SPECIAL REPORT

1981 Maternal Health Conference to follow high-risk infant's hazardous course

Bharti Manchandia, MD, of neonatal intensive care unit at E.W. Sparrow Hospital, Lansing, performs a sophisticated audiology test on a sleeping newborn.

“Life after stress” — the ne nate's, the mother's and t father's — is the concern of the pla ners for the 20th annual Michig Conference on Maternal an Perinatal Health. The conference planned March 25-26 at the Hya Regency Dearborn.

The complete program, abstrac of presentations planned, speake and their professional titles are d scribed in this issue to help MSM members plan their attendance at t meeting. The registration form a pears on page 6.

Annually approximately 1,00 physicians, nurses, medical studen and other health care professiona attend the two-day conference, d signed to improve the care of ne borns and mothers across the state.

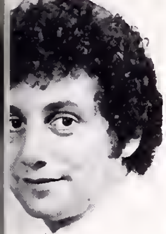
Program chairmen John W. Ha litt, MD, Flint, and Gerald B. Hol man, MD, East Lansing, have car fully designed the program this ye to follow the high-risk mother an infant through their hazardou course.

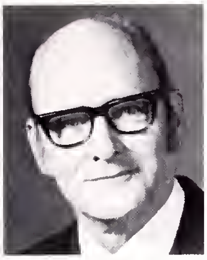
The studies begin with th mother and infant under stress, fo low the health care team's decisio on whether or not to resuscitate t infant after birth, and the emotion impact on the health care team of i life and death decision. The confe ence will continue with help f medical professionals in dealing wit the emotions of parents caught up i the drama, and then work with th sources of help available in th community as the child grows.

Eleven speakers from Michiga and seven other states will prese segments of the program. The pr gram has been approved for 11 hou of Category I continuing medic education credit, and 11 hours

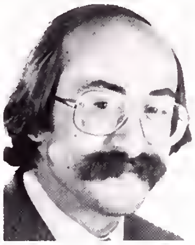
continued on page

ere are speakers, topics and abstracts f Maternal Health Conference talks


shitz


Macintyre

Maisels


Meisels

Pesut

Warshaw

ffrey Lipshitz, MB, ChB, associate professor, Division f Maternal/Fetal Medicine, Department of Obstetrics nd Gynecology, University of Tennessee, Memphis

nagement of Premature Labor: Tocolysis and Fetal cts"

hough prematurity has for long been recognized as the n cause of perinatal morbidity and mortality, it is only ntly that the first tocolytic drug has received approval is country. However, as with most drugs, therapeutic efits are accompanied by adverse effects which occa- ally may be life-threatening. Enthusiastic overuse and r selection of patients have compounded this prob-

.

In order to increase the benefit-to-risk ratio, the prac- ng physician will need to become proficient in the fol- ing areas:

(a) How to select the mother and fetus in whom the of ritodrine will be of no benefit and/or harmful.

(b) The tocolytic, cardiovascular and metabolic ef- s of the B-stimulants.

(c) How to most effectively use these drugs in the tment of preterm labor.

1. Neil Macintyre, PhD, professor, Departments of natomy, Medicine, and Pediatrics, Case Western Re- rve University School of Medicine, Cleveland

hat Happened to Our Baby and What's Happening Js?"

eryone's attention was focussed on our baby and no- y seemed to realize that something frightening was pening to us." "Doctors and nurses seemed to back y and turn us off by becoming very clinical and matter- act in their statements." "I was afraid to tell anyone real feelings about the baby because I was sure I would ondemned by them."

These statements and many similar to them heard eatedly during the course of genetic counseling of ples who had produced a birth defective child ulated the speaker 10 years ago to become involved protracted, in-depth counseling of such couples. lysis of the audio tapes made during these counseling ions with numerous couples over the 10 year period revealed the existence of several parental reaction erns which are common to such cases and the discussion will deal with the most predictable of these patterns.

- **M. Jeffrey Maisels, MB, BCh,** professor of pediatrics and obstetrics and gynecology, and chief, Division of Newborn Medicine, Milton S. Hershey Medical Center, Pennsylvania State University, Hershey

"Organization of the Resuscitation Team"

The first minutes of life may determine the quality of that life. Prompt, organized, and skilled response to emergencies in this period requires that institutions delivering maternal-infant care have written policies delineating responsibility for immediate newborn care, resuscitation, selection and maintenance of necessary equipment and training of personnel in proper techniques. Each institution should develop a list of maternal and fetal complications that require the presence in the delivery room of an individual qualified in newborn resuscitation.

The individual who delivers the baby is responsible for the immediate post-delivery care of the newborn unless another person assumes this duty. Commonly, routine care of the healthy newborn may be delegated to appropriately-trained nurses.

Recognition and immediate resuscitation of the distressed infant require an organized plan of action and immediate availability of qualified personnel and equipment. In general, the individual who resuscitates the newborn should be the one who is best qualified to do so.

A physician must be designated to assume primary responsibility to establish standards of care, review of practices, maintenance of appropriate drugs, and training and evaluation of personnel. Planning must include specific identification and immediate in-house availability of qualified personnel 24 hours a day.

- **Samuel J. Meisels, EdD,** program director for special education, Institute for the Study of Mental Retardation and Related Disabilities, associate professor and chairman, special education, University of Michigan

"Enhancing Caregiver/Infant Interactions"

The focus of this presentation will be the effects of the quality of parent/infant interaction on the child's development. Specifically, the role of the NICU and the transition to community services will be discussed in the context of enhancing positive interactions between parents and their high risk infants.

Willson

- **Daniel J. Pesut, RN, MSN,** assistant professor, Psychiatric-Mental Health Nursing, University of Michigan School of Nursing, Ann Arbor

"Professional Well-Being: Resuscitation of the Health Professional Experiencing Burnout"

The health professional who is experiencing "burnout" may need a special type of "psychological resuscitation." Burnout is a psychophysiological phenomena and may or may not respond to diverse psychological or physical treatment modalities. The objective of this presentation is to discuss the elements of professional well being and resuscitation strategies for the health professional who may be experiencing Burnout.

- **Joseph B. Warshaw, MD,** professor of pediatrics and obstetrics and gynecology, Yale University School of Medicine, New Haven

"Pediatric Management of the Intrauterine Growth Retarded Infant"

Intrauterine growth retardation can result from multiple environmental and genetic factors. Since infants with intrauterine growth retardation may have marginal and substrate reserves they are particularly susceptible to birth asphyxia and problems of newborn metabolic homeostasis. This discussion will review the basis of intrauterine growth retardation and the consequences of this insult to the newborn infant.

- **J. Robert Willson, MD,** professor, Department of Obstetrics and Gynecology; Bates Professor of Diseases of Women and Children, University of Michigan

"The Next Twenty Years: A Review and a Challenge"

The background, changes and problems, in the training of obstetrician-gynecologists in the practice of obstetrics-gynecology and suggestions for improvement during the next twenty years will be discussed.

Maternal Health Conference educational goals

From attendance at this conference, the 20th Annual Michigan Conference on Maternal and Perinatal Health, the participant will gain insight and understanding in the following:

1. The methods for clinical assessment of a patient in premature labor.
2. An analysis of expected risks and benefits of potential treatment for premature labor — specifically, Ritodrine.
3. Considerations for the obstetrician when intrauterine growth retardation is expected.
4. Diagnostic and therapeutic approaches to the infant delivered following intrauterine growth retardation.
5. Analysis of the medical, ethical, and legal considerations involved in neonatal resuscitation.
6. Organization of hospital and medical services to provide optimal resuscitation in the delivery room.
7. Methods of neurological assessment and their correlation with the subsequent development in the neonate.
8. Major factors affecting the emotional needs of parents who are presented with a neonatal death or a handicapped child.
9. Major factors involved in job satisfaction and its converse "burn-out."

High-risk infants' hazardous course

continued from page 6

prescribed credit by the Americ
Academy of Family Physicians.

The 1981 conference is a joint
fort by 10 groups. While MSM
coordinates the program and mal
physical arrangements, handling
publicity, registration and a host
other activities related to the conf
ence, the list of cooperating grou
continues large.

This year's meeting is made p
sible through the efforts of the f
lowing organizations:

Michigan State Medical Societ
Michigan Academy of Fam
Physicians;

Michigan Association of Pedi
ric Nurse Associate Practitioners;

Michigan Chapter, Americ
Academy of Pediatrics;

Michigan Department of Pub
Health;

Michigan Nurses Association;

Michigan Section, Nurses A
sociation, American College
Obstetricians and Gynecologists, D
trict V;

Michigan Society of Obstet
cians and Gynecologists;

Perinatal Association of Mic
gan, and

Wayne County Medical Societ

The planning committee is co
prised of:

John W. Hallitt, MD, Flint,
chairman; Gerald B. Holzman, M
East Lansing, co-chairman; Moha
mad A. Aussie, MD, Lathrup Villa
Linda D. Bond, RN, Ann Arb
Robert C. Borer, Jr., MD, Detroit;
Arch Brown, MD, Flint; Lauren
Bruggers, MD, Saginaw; Phyllis
Carter, RN, Flint; Mary Conklin, R
Lansing; Miriam S. Daly, MD,
bion; Clinton H. Dowd, MD, Fli
John V. Hartline, MD, Kalamaz
Mary J. Kokosky, MD, Dearbo
Federico G. Mariona, MD, Detr
James N. Martin, Jr., MD, Ann Arb
Ronald L. Poland, MD, Detr
Dorothy A. Porter, MD, Lathrup V
lage; Jean M. Read, RN, Flushi
Dietrich W. Roloff, MD, Ann Arb
Mary Scoblic, RN, Lansing, and
B. Stevenson, MD, Southfield.

lere is Maternal Health Conference rogram and registration form

dnesday Morning, March 25

5 a.m. "Management of Premature Labor: Tocolysis Fetal Affects" — Jeffrey Lipshitz, MB, ChB, associate fessor, Division of Maternal/Fetal Medicine, Department of Obstetrics and Gynecology, University of Tensee, Memphis

0 a.m. "Diagnosis and Management of Intrauterine wth Retardation: The Mother" — James Crane, MD, stant professor, Head of Genetics Unit, Barnes Hospi- St. Louis, MO

5 a.m. "Pediatric Management of the Intrauterine wth-Retarded Infant" — Joseph B. Warshaw, MD, fessor of pediatrics, obstetrics and gynecology, Yale versity School of Medicine, New Haven, CT

30 a.m. Panel Discussion

dnesday Afternoon, March 25

0 p.m. "The Critical First 10 Minutes of Life" — ard W. Ostheimer, MD, assistant professor of anaessia, Harvard Medical School, associate director of etrical anaesthesia, Brigham and Women's Hospital, ton

0 p.m. "Ethical and Legal Issues in Resuscitation of Newborn" — Norman Fast, MD, MPH, assistant proor of pediatrics, director of programs in medical cs, director of residency program, University of Wissin Medical School, Madison

0 p.m. "Organization of the Resuscitation Team" — Jeffrey Maisels, MB, BCh, professor of pediatrics and tetrics and gynecology, Chief, Division of Newborn dicine, The Milton S. Hershey Medical Center, nsylvania State University, Hershey, PA

5 p.m. Panel/Questions and Answers

Thursday Morning, March 26

8:45 p.m. "Professional Well-Being: Resuscitation of the Health Professional Experiencing Burnout" — Daniel J. Pesut, RN, MSN, assistant professor, Psychiatric-Mental Health Nursing, University of Michigan School of Nursing, Ann Arbor

10:00 a.m. "Neonatal Neurologic Assessment and Projected Outcome" — Gary Goldstein, MD, University Hospital, Ann Arbor

10:45 a.m. "What Happened to Our Baby and What's Happening to Us?" — M. Neil Macintyre, PhD, professor, Departments of Anatomy, Medicine, and Pediatriacs, Case Western Reserve University School of Medicine, Cleveland

11:30 a.m. Panel/Questions & Answers

Thursday Afternoon, March 26

1:30 a.m. "Discharge from the Neonatal ICU" — PANEL: Marianne Glassanos, RN, clinical nurse specialist, Holden Neonatal Nursery, University of Michigan Hospital, Ann Arbor
Steve Donn, MD, University of Michigan Medical Center, Ann Arbor
Lillie Leverett, RN, Visiting Nurses Association of Detroit, Detroit
Samuel J. Meisels, EdD, program director for special education, Institute for the Study of Mental Retardation and Related Disabilities, University of Michigan, Ann Arbor

3:15 p.m. "The Next Twenty Years: A Review and a Challenge" — J. Robert Willson, MD, professor, Department of Obstetrics and Gynecology; Bates Professor of Diseases of Women and Children, University of Michigan Medical School, Ann Arbor

---

program is approved for 11 hours of CME Cat- ry I credit, and accepted for 11 prescribed hours by The American Academy of Family Physicians.

Advance Registration

nplete and mail to the Michigan Conference on Maternal and Perinatal Health, Box 950, East Lansing, MI 48823

ne ____________________

lress ____________________

____________________ **Zip** ________

Please check one:

Physician	RN	LPN	Student	Other
☐	☐	☐	☐	☐

istration Fee:		Physician	Nurse	Other	Student/House Officer
se Check	Wednesday Sessions	☐ $20	☐ $12	☐ $12	☐ No Charge
	Thursday Sessions	☐ $20	☐ $12	☐ $12	☐ No Charge
	Total	$	$	$	$ (none)

e checks payable to Michigan State Medical Society

Aspirin could cause Reye's

A recent article in various newspapers brought up the question of a possible link between aspirin usage and Reye's Syndrome.

I was first introduced to this often-fatal triad of fatty degeneration of the liver, hypoglycemia and encephalopathy some years ago as an intern. My interest was aroused to the point of writing a paper on this syndrome, which I presented at a local scientific meeting in Michigan. Since that time, some years ago, I've continued to follow developments involving treatment, cause, prognosis and prevention.

Earlier thinking in some medical circles incriminated a lipovirus of some kind. Others suspected drugs and/or toxins. Still others suspected idiosyncratic defense mechanisms leading to host self-destruction. To date, and to the best of my knowledge, no one cause stands alone. And herein, I believe, lies a significant clue — one which should not be ignored.

Can aspirin cause or precipitate this serious illness? I believe so. Salicylates can indeed affect glycogen storage and glucose metabolism, liver integrity, pH and sensorium. Especially in sick children who have been challenged by infections, fever, dehydration and a "host" of other problems.

Furthermore, an aspirin link should suggest carrying this question a step beyond: what about other drugs, such as tylenol? Or, for that matter, many other medications metabolized by, or cleared through, the liver and kidneys.

I would like to urge further research in this area. Meanwhile, I am confident in the belief that drugs should be used with caution (something we know but tend to forget!) in sick children having various illnesses, especially viral, who become febrile, dehydrated and weakened. Hydration and cooling techniques should be re-emphasized, as should frequent medical followup in those situations where Reye's is a distinct possibility.

When this condition was first described some years ago, we had a somewhat myopic view of it all. Now that years have passed and new cases and information have come to the fore, we have a broader, more enlightened overview. Let's continue and press for more answers.

My children thank you.

Frank J. Korn, MD
Portage

Joint Commission seeking physician team members

The Joint Commission on Accreditation of Hospitals, a private, not-for-profit organization, would like to ask your assistance in our search for physician surveyors who are interested in helping hospitals throughout the country provide the highest possible level of health care services through education, evaluation and consultation.

The JCAH physician survey team member is responsible for a broad spectrum of activities. Evaluation of hospital medical staff functions and quality assurance activities and evaluation of anesthesia, dental, emergency, nuclear medicine, pathology, radiology and medical records services are examples of the comprehensive scope of the survey process.

Qualifications for this position include current medical licensure, extensive clinical and patient care management experience, at least 10 years of service on a hospital medical staff, strong oral and written communications skills, excellent physical health, and, a strong desire to participate in this voluntary national quality assurance process.

All interested candidates are invited to call for additional information (312/642-6061, ext. 333) or send their resume to Janet L. Heckman, Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, 60611.

Janet L. Heckman
Manager of Compensation and Employment
Joint Commission on Accreditation of Hospitals, Chicago

MCAAP campaigning to make first ride home a safe ride

The Michigan Chapter of the American Academy of Pediatrics is launching an intensive campaign to reduce the number of deaths and injuries of children riding in cars.

We encourage all members of the Michigan State Medical Society to remind children over the age of four to use seat belts. Additionally, through an educational effort, pediatricians will be insisting that all newborns leaving the hospital are transported home in an approved car passenger seat, rather than in the mother's lap. The mother's lap has been renamed the "child-crusher position," because infants and small children riding on laps in the front seat are crushed by the parent's body against the car dashboard at the time of an auto crash.

Finally, the Michigan Chapter of the American Academy of Pediatrics implores all physicians to actively support passage of House Bill HB5327 by the Michigan Senate when it reaches the Senate floor for debate and vote in the next few months.

HB5327 would require the use of a car passenger safety seat for all children four years of age and under in Michigan automobiles. The use of such a seat can reduce the loss of infant lives by 90 percent or better.

There has never been a reported death of a child under the age of four involved in a crash when the child was riding in an approved car passenger safety seat, properly secured within the seat and the seat properly secured within the car.

A list of senators who voted "no" when HB5327 was narrowly defeated earlier this year is available from **MSMS**. These legislators are looking to **MSMS** for guidance on this issue.

Please help us to make the first ride home a safe ride, as well as all future rides in Michigan automobiles.

Marshall J. Blondy, MD
Alternate Chairman
Michigan Chapter, AAP
Livonia 48152

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When
impotence
is due to androgenic deficiency.

Android® /5 Buccal mg. /10 Oral mg /25 Oral mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

The exhibit hall at the 1980 MSMS Annual Scientific Meeting was a place for physicians attending the meeting to gather, discuss courses they were attending and learn of the latest medical products available for use in their practices. The 1980 meeting was attended by 1,200 physicians and was staged at the Hyatt Regency Dearborn.

One of the most productive learning sessions took place during the Annual Scientific Meeting course on Current Management of Renal Failure. Presented by the Division of Nephrology at Henry Ford Hospital, and led by course director Nathan W. Levin, MD, Detroit, the course broke into small work groups like the one above to consider treatments for specific cases.

Photo highlights of 1980 MSMS Scientific Meeting

Faculty members for the course on the physician as expert witness arranged mock courtroom testimony for their audience. From left, they are J. Douglas Peters, JD, Ann Arbor; Daniel Bronstein, JD, Detroit, and Donald A. Kroll, MD, PhD, Ann Arbor.

Michigan Physicians Mutual Liability Company

WHERE PHYSICIANS MAKE THE DIFFERENCE

Physician owned and controlled MPMLC now offers up to one million dollars in coverage. The highest limit available in Michigan.

MPMLC also offers a 50 percent rate reduction for all physicians in their first year of practice, having a part-time private practice, or who are semi-retired.

Call or write us for a free introductory information kit.

Michigan Physicians
Mutual Liability Company

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

P.O. Box 1471
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926 toll free

Your
Company

Michigan Physicians Mutual Liability Company is not a creation of government It is the company formed by doctors who would rather shape their own solutions to the medical malpractice insurance problem.

The purchase of a "surplus certificate" for insurance is no longer required.

REFUGEE REPORT

Michigan physician horrified by 'Second Holocaust' in Cambodia

By R. J. Weiss, MD, Ann Arbor

The human misery witnessed by Doctor Weiss and others who have traveled to Cambodia to aid the refugees has fired their commitment to the displaced Southeast Asian populations.

Having just relocated to Michigan, I have come in contact with the state medical society's effort to aid the Indochinese refugees. The society and its members should be commended for this effort.

I was fortunate to be able to spend December 1979 and January 1980 in a Khmer refugee camp helping to staff a pediatric field hospital unit. This was far and away the most meaningful experience of my personal and professional life.

Although it was very difficult and demanding, the sense of giving and accomplishment was truly overwhelming.

All too many of us who are recently trained have spent too long learning how to interpret data. The science of medicine has become more important than the art.

In the camps there was precious little objective data. We were able to take a history through an interpreter and do a physical examination. Based solely on this information we had to treat critically ill and malnourished people.

But more than that, we had to plan public health facilities, teach the barefoot Khmer to become doctors and nurses, establish supplemental feeding centers, reunite families. We had to decide what constituted the correct therapy for malaria in this area, if these children could absorb and digest milk, who should be vaccinated. All this had to be done in a remote area using whatever supplies happened to be available. In many ways it was truly total care.

When I returned to my home in Vermont, I established a fund-raising drive in that state which permitted me to buy laboratory equipment for the camp in order to take much of the guesswork out of the care of these desperately sick people.

The response from the people
Vermont was both gratifying and i
teresting. Many people wrote thanl
ing me for being a physician that wa
not molded in the stereotype of th
doctor-businessman.

Certainly this is a generalizatio
that all of us are familiar with. Mar
physicians certainly do not fit it, bu
enough must in order for the pul
lic's perception of our profession t
have changed so drastically.

The Indochinese refugee prol
lem will be with us for a long tim
The Khmer problem in specific ha
been termed a Second Holocaus
Many refugees are still in the camp
and now many are coming to th
States.

As physicians we should have
deep understanding for the sufferin
of all people. Do we do enough?
think not.

As a rule, most of the physiciar
in the camps were either at the be
ginning of their careers or at the enc
This meant a shortage of highl
trained personnel.

And even here at home, man
public health departments are unabl
to find volunteer physicians to hel
in the screening of the new arrival
The National Cambodian Crisi
Center in Washington, DC whic
oversees the nationwide drive t
raise monies for the Khmer has bee
somewhat disappointed by the re
sponse of physicians in this country

Not everyone is in a position t
be able to go to a refugee camp. Ye
every physician should be in a pos
tion to help in some way. At preser
the international voluntary agencie
are trying to care for refugees in Ir
dochina, Pakistan, Somalia an
Uganda, to name just a few. Here i
Michigan there is a Refugee Relie
Fund. During recent months th
Khmer population has been totall
dependent on outside aid for foo
while awaiting the first possible ha
vest since 1975.

Being able to help as much as
did both in the camp and since I hav
returned has been a gift to me. A
concerned people can share in tha
gift by doing something.

With the Khmer we are trying t
save the remnants of an entire race
This only will be successful if thos
of us who have enough and are awar
enough step forward.

Doctor Weiss is with the University Hospital Heart Station, where he is studying under a three-year cardiology fellowship.

Michigan Department of Social Services anks leading diagnoses among refugees

litor's note: The following ar-
:le is written from a detailed
port prepared by the Michigan
:partment of Social Services.
SMS gratefully acknowledges
e work of the MDSS. Copies
the complete report are avail-
le on request to Dennis Paradis,
SMS headquarters, 517/337-
51.

n order to better understand utilization of the health care system Indochinese refugees, MSMS requested data from the Michigan Department of Social Services regarding most common diagnoses for Indochinese refugees in the Medicaid program. Because all refugees are eligible for the Medicaid program, this data has great ability to characterize the entire refugee population.

The information supplied by MDSS covered an 18-month period from January 1979 to June 1980 and included 1,421 individuals, which are about 20 percent of the total Indochinese refugee population in Michigan.

Age Group	Male	Female	Total
0- 5	156	122	278
6-14	194	132	326
15-21	130	99	229
22-44	219	234	453
45-64	70	65	135
Total	769	652	1,421

Findings

It is not possible to compare these statistics to the general popula-

Common Primary Diagnosis for Indochinese Refugees

January 1979-June 1980
(N = 1421 patients/5381 primary diagnosis)

ignostic category Common primary diagnosis (N > 100)	Number	% of patients with diagnosis
ectious and parasitic diseases	656	(46.1%)
Pulmonary tuberculosis	108	(7.6%)
Intestinal parasites and hookworm	163	(11.4%)
Miscellaneous infections and parasitic diseases	121	(8.5%)
oplasms	34	(2.3%)
locrine, nutritional and metabolic disorders	251	(17.6%)
Anemias	100	(7.0%)
ntal disorders	10	(.7%)
eases of nervous system and sense organs	448	(31.5%)
Refractive errors	102	(7.1%)
Otitis media	145	(10.2%)
eases of circulatory system	190	(13.3%)
eases of respiratory system	903	(63.5%)
Acute upper respiratory infections	191	(13.4%)
Pneumonia	102	(7.1%)
Bronchitis	113	(7.9%)
eases of digestive system	256	(18.0%)
eases of genito-urinary system	273	(19.2%)
nplications of pregnancy, childbirth, and puerperium	113	(7.9%)
eases of skin and subcutaneous tissue	208	(14.6%)
eases of musculoskeletal system and connective tissue	149	(10.4%)
igenital anomalies	28	(1.9%)
iditions originating in perinatal period	21	(1.4%)
nptoms, signs and ill-defined conditions	660	(46.4%)
Respiratory abnormalities	107	(7.5%)
Symptoms involving abdomen and pelvis	130	(9.1%)
Abnormal laboratory findings	104	(7.3%)
ry and poisonings	336	(23.6%)
plemental classifications	845	(59.4%)
Supplementary conditions related to pregnancy	418	(29.4%)
General medical examinations	225	(16.1%)
Special examinations	112	(7.8%)

Attention Doctors and Medical Laboratories

Now receive Blue Shield payments every eight days!

- Patient Insurance
- Accounts Receivable
- Terminal Setup
- Magnetic Tape Billing
- Processing and Handling

Daily Delivery to Blue Cross-Blue Shield & Medicare

All Other Insurance Companies

Dempsey Data Service

G7252 Fenton Road
Grand Blanc, Michigan 48439

(313) 738-2280

REFUGEES/*continued*

tion because they are not age- or sex-adjusted. However, we can glean some assumptions from this data.

Not unexpectedly, infectious and parasitic diseases account for a large number of primary diagnoses. Pulmonary tuberculosis is the major public health threat. Other infectious diseases which deserve special mention are: polio-myelitis (4 cases = .2 percent), rubella (12 cases =.8 percent), viral hepatitis (1 case = .07 percent), malaria (34 cases = 2.3 percent) and syphilis (8 cases = .5 percent).

Also not surprising, is the high incidence of diagnosis for endocrine, nutritional and metabolic disorders. Other diagnoses of interest in this category are goiter (14 cases = .9 percent) and diabetes mellitus (48 cases = 3.3 percent). The depleted nutritional status of some refugees must be medically addressed because of the synergistic relationship between nutrition and disease. This becomes a difficult task, since the refugee is unable to obtain culturally familiar foods and is learning food habits for this country.

Another noteworthy indicator is the incidence of the diagnosis for diseases of the respiratory system. 63.5 percent of the refugees in the sample yielded a primary diagnosis of respiratory disease. Some of this disease may be attributable to th generally depleted health status o the refugee population, but th physician should also be aware o refugee's lack of familiarity with th Michigan climate.

Perhaps the areas most in nee of comment are where the data is no as expected. Despite the low incidence of the diagnosis for menta disorders (.7 percent), field staff indicate that mental health problems ar common among Indochinese refugees.

This is not unexpected given th life stresses to which the Indochines refugees have been subjected.

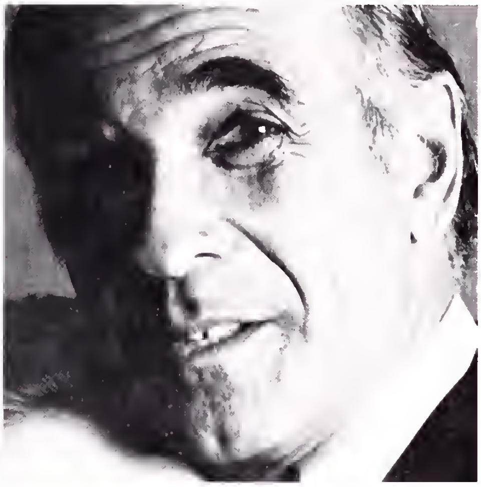
The relatively low number o mental disorder diagnoses may be attributable to language and cultura barriers that hinder effective patient-physician communication. I may also be that Indochinese refugees don't consider it proper to seel medical help for mental health problems.

Traditional practices dictate tha the family or religious leaders are th support group to call in this situation. Unfortunately, these suppor mechanisms may not exist in thi country.

Of greatest concern is the frequency of the diagnoses that indicat problems with pregnancy or deliver Within the sample population, ther were 333 women of child-bearing ag (15-44). A generous assumption i that 20 percent of these women (67 were pregnant in the 18-month stud period. These estimated 67 pregnancies resulted in 552 primary diagnoses related to pregnancy, childbirth or perinatal problems. Forty-two of these diagnoses are for norma delivery and 22 are for induced o spontaneous abortion. The bulk o these diagnoses (418) fall into th category "supplementary condition related to pregnancy." With an estimated 67 pregnancies and 552 related diagnoses, it must be suspecte that the added stress of pregnanc and childbirth result in the exhibition of numerous medical problem in the mother and child. The pregnancy and delivery of the Indochinese refugee should be evaluate from the assumption of a recent history of high stress, poor sanitatio and poor diet.

more on page 18

NOW THAT HIS
EDICAL PROBLEM IS GONE...



SO IS HE.

When one of your patients fails to pay, it's tough to collect. But when he moves out of state, it's next to impossible. That's why your association approved I.C. System – a nationwide collection service. Whether a debtor has moved across town or across the country, let I.C. cover the extra miles for you. Mail this coupon today to learn how far...

**The System
Works**

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ______________________________
Address ______________________________
City ______________________________
State ______________________ Zip__________
Signature ______________________________

Refugees in America suffer from loss of community

The following article is adapted from a paper, "Indochinese Refugees' Mental Health Needs and Considerations," presented by K. Patrick Okura at the 1980 American Public Health Association Annual Meeting Oct. 19-23 in Detroit. Mr. Okura is Assistant Director for International Programs and Special Assistant to the Director for Asian/Pacific Americans and Refugee Programs, National Institute of Mental Health.

The U.S. has received far more refugees from Indochina for resettlement than has any other country. Since 1975, Americans have seen 289,179 refugees come to the US. (HEW, Report to Congress, Dec. 31, 1979).

Because of the diversity of the refugees' experiences in escaping intolerable conditions in their homelands, in camp internment, and in resettlement in the US, not enough is known yet as to whether any pattern of developmental problems exist.

Obviously though, the Indochinese populations have undergone a good deal of stress in accommodating to the varied cultural differences of life in the United States.

But until recently, mental health care for migrant populations has received scant national attention. Therapeutic interventions have lacked sensitivity to cultural values and language differences, chiefly due to the lack of properly-trained mental health professionals.

Language barrier

Language has been the first and most formidable barrier to use of mental health services.

The refugees' cultural backgrounds and value systems also are completely different from those of Americans. Kluckon and Strodbeck (1961) stated that Americans perceive human nature as "basically evil but perfectible," whereas Indochinese believe that human nature is basically good, however, corruptible.

Euro-American civilization has been built on overcoming and mastering nature, while Indochinese culture stresses harmony with nature.

Americans look to the future and build for progress. The Indochines cherish and uphold their ties wit the past and history.

Americans are oriented towar "doing" goal-oriented tasks, whil the Indochinese prefer activities tha develop the human essense, such a self-control and meditation.

Finally, while Euro-America culture stresses individualism, Indochinese cultures place value on kinship. An American achieves b standing out while an Indochines achieves by blending in with his family or community network. The majo mode of resolution for personal an interpersonal problems has been t rely on elders in the family, the leaders of the community and othe community support mechanism rather than professional interventions.

Support destroyed

However, with the policy to disperse the Indochinese across the nation and effectively "hide" them i the general population, the community support network so valued b the Indochinese populations ha been destroyed. It prohibits the possibility of viable and cohesive Indochinese ethnic communities bein formed.

Such isolation does not fare we for them. Their well-being depend culturally and emotionally, almo exclusively on an integrated community and kinship support netwo (Tung, 1972; Barnes, 1957).

Therefore, this mode of problem-solving places a very low priori on seeking help from outside resources, whether for mental heal or for medical problems.

The need to bring services to t resettled refugees' homes, rather tha requiring them to come to the "office," as well as the need to rebuild supportive community among t refugees, seem to be the necessa considerations for the refugee sound mental health.

A few more active TB cases found among Michigan refugees this year

The following is reprinted with permission from "The Circular," newsletter of the Michigan Department of Public Health.

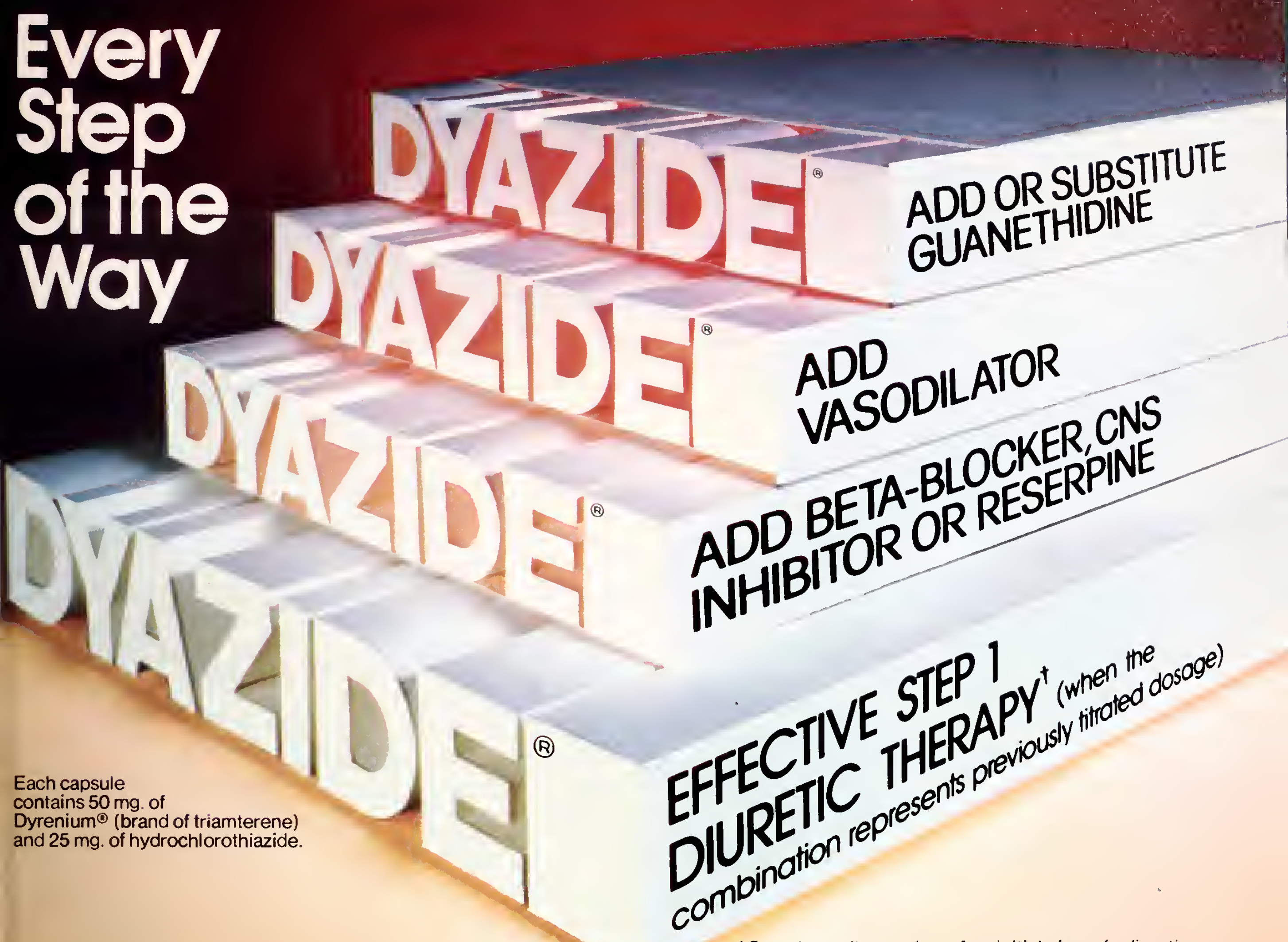
Recent media coverage concerning the nineteen percent increase in the number of tuberculosis cases in Michigan this year has cited the refugees as the cause of this increase and given the impression that, as a group, they represent a significant threat to our citizens.

While tuberculosis is the number one public health problem among the refugees, all the information received to date indicates that they are not speading the disease to our residents. This is primarily due to the fact that active cases are placed on treatment while still in the overseas camps and are not allowed to enter the United States until smear negative and that, once here, they are followed closely by our local health departments.

We do have a significant increase this year in the number of refugees with active TB. This is due, in part, to the increased influx of refugees and the temporary removal of the medical excludability requirement during March, April and May of this year. During the past five years (1975-79) there has been an average of about 20 cases a year among the refugees. This year we already have approximately 100 cases. The total case count for Michigan this year is running about 160 cases ahead of last year. One-half of this increase can be attributed to the refugees.

The last five years has been a period in which the number of cases reported annually has fluctuated, with the average number of cases per year at 1244. Even with the increase this year we do not anticipate exceeding this average. However, if this trend should continue during 1981, with a large number of new cases above and beyond those found in the refugee population, there would be cause for concern.

In Hypertension*...When You Need to Conserve K$^+$


Every Step of the Way
DYAZIDE®
ADD OR SUBSTITUTE GUANETHIDINE
DYAZIDE®
ADD VASODILATOR
DYAZIDE®
ADD BETA-BLOCKER, CNS INHIBITOR OR RESERPINE
DYAZIDE®
EFFECTIVE STEP 1 DIURETIC THERAPY† (when the combination represents previously titrated dosage)

Each capsule
contains 50 mg. of
Dyrenium® (brand of triamterene)
and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K+ supplement or K+-sparing agent and a maintenance phase (a diuretic alone or in combination with a K+ supplement or K+-sparing agent).

Serum K$^+$ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

*
> **WARNING**
> This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

© SK&F Co., 1980

SK&F CO.
a SmithKline company
Carolina, P.R. 00630

AN EXCEPTIONALLY FAVORABLE

You can expect rapid relief of a broad range of symptoms

With Limbitrol, patients often improve within a week. Not only is insomnia relieved, but you will often see early relief of agitation, psychic and somatic anxiety, anorexia and feelings of guilt or worthlessness. This early response encourages patients to stay in therapy.

You can minimize phenothiazine drawbacks

When you choose Limbitrol over a phenothiazine-containing product, you minimize the risk of tardive dyskinesia — now associated even with low dose, short-term phenothiazine therapy.[1,2] You also reduce the possibility of other extrapyramidal side effects, which occur in approximately 30% of patients receiving phenothiazines.[3-5] In contrast, the reported incidence of these disturbing reactions with Limbitrol or either of its components alone is rare. (For a complete list of side effects reported with Limbitrol, please consult full disclosure.)

References: 1. Paulson GW: *NY State J Med 79:*193-195, Feb 1979. **2.** Hattister LE Antipsychotic medications and the treatment o schizophrenia, chap. 9, in *Psychopharmacolog from Theory to Practice*, edited by Barchas JD *et al*. New York, Oxford University Press, 1977 pp.134, 145. **3.** Domino EF. Antipsychotics. phenothiazines, thioxanthenes, butyraphenan and rauwolfia alkaloids, chap. 25, in *Drill's Pharmacology in Medicine*, ed.4, edited by DiPalma JR. New York, McGraw-Hitt Book Company, 1971, p.476. **4.** Savner R, DiMasci Extrapyramidal syndromes and other neurolog side effects of psychotropic drugs, in *Psychopharmacology: A Generation of Progress*, edite Lipton MA, DiMoscia A, Killam KF. New York, Raven Press, 1978, p.1021 **5.** Donlon PT, Stenson RL. *Dis Nerv Syst 37* 629-635, Nov 1976.

ROCHE®

AFETY/BENEFIT RATIO

What better reason to choose Limbitrol for your patients with moderate depression and anxiety?

Limbitrol® ©IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

LIMBITROL®
10-25
LIMBITROL®
5-12.5

Efficacy without a phenothiazine

Please see summary of product information on following page.

Your guide to patient management... when you decide medication is needed

How to initiate and maintain therapy

Select dosage strength appropriate for each patient

☐ Limbitrol 5-12.5 is recommended to minimize drowsiness and for elderly patients

☐ Limbitrol 10-25 may be indicated for patients who tolerate medication without undue side effects

Specify daily dosage based on symptom severity

☐ An initial dosage of three tablets is recommended

☐ Dosage may be increased to six tablets or decreased to two tablets daily as necessary

☐ Once a satisfactory response is obtained, patients should be continued on the smallest dose required to maintain the desired effect

Utilize dosage options to best accommodate individual patient needs

☐ T.I.D. or Q.I.D., familiar regimens most suited for patients who tolerate medication without undue drowsiness

☐ Two tablets one hour before bedtime and one tablet midday may minimize daytime drowsiness and help relieve a common target symptom — insomnia

☐ Entire dosage h.s. to take maximum advantage of the sedative effect

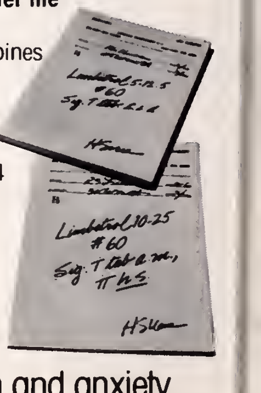
How to make each patient an informed patient

1. Discuss with patients the probability that they will experience drowsiness, especially during the first week.
2. Reassure your patients that drowsiness is one indication that the medication is working and that it may help alleviate their insomnia.
3. Encourage patients to report if drowsiness becomes troublesome so that, if necessary, dosage schedule can be adjusted.
4. Caution patients about the combined effects with alcohol or other CNS depressants. Let them know that the additive effects may produce a harmful level of sedation and CNS depression.
5. Caution patients about activities requiring complete mental alertness, such as operating machinery or driving a car.
6. Warn pregnant patients and patients of childbearing age that the safety of Limbitrol in pregnancy has not yet been established.

Please see complete product disclosure for other pertinent information

Limbitrol should not be used under the following circumstances:

1. Hypersensitivity to benzodiazepines or tricyclic antidepressants.
2. Concomitantly with an MAO inhibitor. To replace an MAO inhibitor with Limbitrol, discontinue MAO inhibitor for a minimum of 14 days before cautiously initiating Limbitrol therapy.
3. During the acute recovery phase following myocardial infarction.



In moderate depression and anxiety

Limbitrol®

Relief without a phenothiazine

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses Myocardial infarction and stroke reported with use of this class of drugs) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving)

> ***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients Periodic liver function tests and blood counts are recommended during prolonged treatment Amitriptyline component may block action of guanethidine or similar antihypertensives Concomitant use with other psychotropic drugs has not been evaluated sedative effects may be additive Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment See Warnings for precautions about pregnancy Limbitrol should not be taken during the nursing period Not recommended in children under 12 In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects

Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive I V administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment

Dosage: Individualize according to symptom severity and patient response Reduce to smallest effective dosage when satisfactory response is obtained Larger portion of daily dose may be taken at bedtime Single h s dose may suffice for some patients Lower dosages are recommended for the elderly

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12 5 mg amitriptyline (as the hydrochloride salt) — bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50

ROCHE®

ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

MEDICAL NEWSFRONTS

A total of 38 cases of suspected Tox-c Shock Syndrome (TSS) in Michigan residents has been reported to he Michigan Department of Public Health and/or the National Center for Disease Control. All but four of the cases have had onset of symptoms his year.

Thirty-seven of the cases have been females. Cases range in age rom 13 to 58 years old. Two of the cases are known to have died as a re-ult of their illness.

The Division of Disease Surveil-ance has requested that Infection Control Practitioners (ICP's) report cases of TSS in Michigan residents to both the patient's local health department and the Michigan Department of Public Health. ICP's have also been asked to distribute a study questionnaire to hospitalized menstrual-age patients fitting the case definition for TSS and who survive he acute illness.

An estimated 50-75 cases of TSS will occur in Michigan women each year if cases continue to occur at he present rate (3/100,000/year).

The Division of Disease Surveillance supports the recommendations of the Center for Disease Control regarding the prevention of TSS.[1,2] Women requesting information to help them decide what preventive measures they should take should be advised that:

1) The risk of developing TSS is small (about 3/100,000 women/year).

2) Women can almost entirely eliminate their risk of developing TSS by not using tampons at all.

3) Women who choose to use tampons can reduce their risk by using them intermittently during each menstrual period (that is, not use them all day and all night throughout the period).

According to William H. Foege, MD, Director of the Center for Disease Control, "Great progress made since the National Immunization Initiative was launched in April 1977 has made the present situation extremely favorable for the elimination of measles in the United States by October, 1982. The incidence rate of the disease is low and immunization levels are high. Given a vaccine of high effectiveness with very low risk, effective strategies for control, and the present epidemiologic and programmatic situations, the elimination of measles from the United States not only seems possible but virtually obligatory.

"The single most effective way of achieving and maintaining the immunity levels needed in school-age children has been the enactment and vigorous enforcement of school immunization requirements for attendance at all grade levels, not just at school entry."

There is no evidence of a direct causal connection between artificial food colors and flavors and hyperactivity in children, according to a report issued by the National Advisory Committee on Hyperkinesis and Food Additives.

The findings also generally refute a controversial hypothesis that chemical additives and even certain natural components of common foods cause hyperkinesis in children, a condition that includes hyperactivity plus other symptoms such as short attention span, lack of concentration, impulsiveness, apathy and rebelliousness.

The landmark report concludes that studies — carried out by dozens of investigators over some five years at a cost exceeding one million dollars — "provide sufficient evidence to refute the claim that artificial food colorings, artificial flavorings and natural salicylates produce hyperactivity."

"The fact that the recurrence of a breast cancer is associated with specific characteristics of the cancer cells has enabled Detroit researchers to develop potentially powerful tests for predicting the degree of malignancy in human breast tumors," says Marvin A. Rich, MD, executive vice president and scientific director of the Michigan Cancer Foundation.

Detroit researchers have documented a distinct association between early recurrence of breast cancer and the reactivity of a patient's tumor cells in the test tube with a plant protein called Con A. They also are able to predict the time to recurrence of a breast cancer using a tumor grading system based on tumor and patient characteristics determined through the Breast Cancer Prognostic Study now underway at the Michigan Cancer Foundation.

Severely burned patients are being saved at a higher rate than ever before, and hospitalization periods are being shortened, says a report in the Nov. 7 *Journal of the American Medical Association*.

Improvements in burn care from 1965 to 1979 are tabulated in a report from the National Burn Information Exchange, Ann Arbor, Michigan. Case reports of 37,442 patients collected during those years from 120 burn care facilities are examined.

Survival ratio of all patients, ranging from only minor burns to severe burns, was 81 per cent in 1965-71, up to 86 per cent in 1972-75, and at the level of 90 per cent in 1976-79.

Irving Feller, MD, of the division of burn surgery, University of Michigan, notes that the gains have come about through a notable increase in interest in the care of the burned patient during the last 35 years.

"Basic Nutrition Facts," a booklet summarizing accepted nutrition knowledge relating to health, has been developed by a Task Force convened by the Michigan Department of Public Health. It provides an accurate, up-to-date nutrition reference for use by health professionals and the public.

Requests should be sent to: Nutrition Services, Bureau of Personal Health Services, Michigan Department of Public Health, 3500 N. Logan, P.O. Box 30035, Lansing, MI 48909.

coming May 1981 . . .

the international symposium on normoglycemia for the diabetic Detroit, Michigan

An outstanding international faculty will convene in Detroit, Michigan, on May 6 and 7, 1981, to address the following subjects:

- pancreatic organ transplant
- islet cell transplant
- mechanical insulin delivery systems

The symposium will focus on current experience, problems, possible solutions and projections for the future relating to normoglycemia for the diabetic patient.

Abstracts relating to the symposium are invited and topics will be accepted until February 15, 1981.

Symposium Chairmen
Sander P. Klein, M.D.
Endocrinology

Luis H. Toledo-Pereyra M.D., Ph.D.
Transplantation

Sponsored by:
Eli Lilly and Company and
Mount Carmel Mercy Hospital,
Detroit, Michigan

registration information

Tuition: $100 (US currency); CME credit available. Special rates available for students, nurses and resident physicians.

☐ Yes, I'm interested in attending. Please send me more information.

☐ I would like to submit the following abstract topic for consideration:

Topic ________________________________

____

Name ________________________________

Title ________________________________

Address ________________________________

Mail to: Mount Carmel Mercy Hospital
c/o Transplantation Department
6071 West Outer Drive
Detroit, Michigan USA 48235

VIEWS

I give up

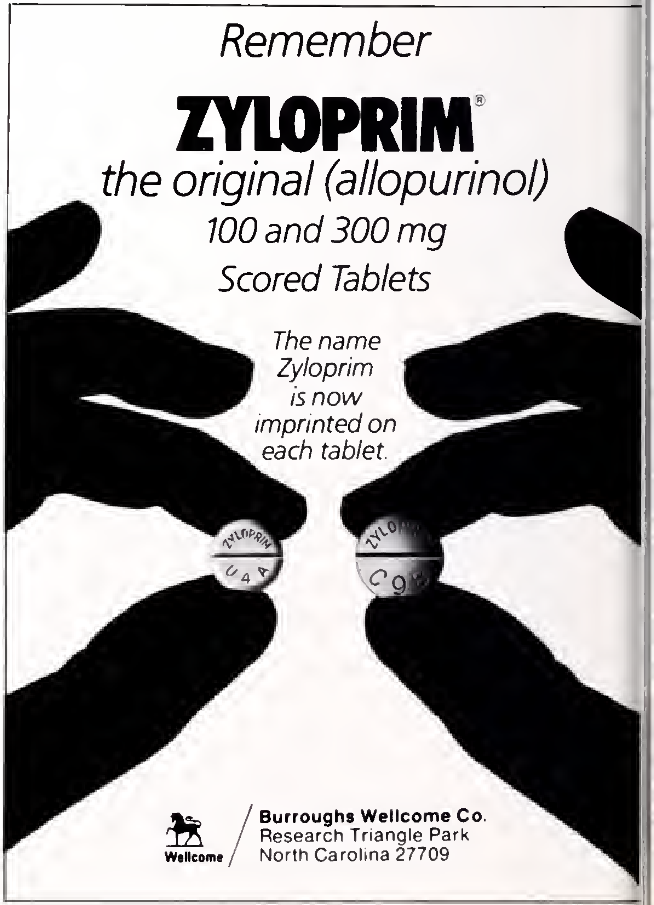
By David Siegel, MD, Lansing

After serving on the MSMS Medicaid Liaison Committee since its inception in 1972, I must admit to myself and to my colleagues that my usefulness in this particular arena has come to an end. Great strides were made at first in accommodating the needs and requirements of the indigent population and of our physician membership. We survived what could have been a disastrous confrontation with state government in 1975 and out of it forged an even stronger program.

The present legislative leadership refuses to understand, or is philosophically incapable of understanding, that they serve the public poorly by punishing unfairly the one provider group that has consistently been able to offer quality services at below budget cost. We are now taken for granted, viewed as an impotent group that will accept whatever the legislature feels is our dole.

For my inability to convince them otherwise, I am saddened and frustrated. I give up!!

Doctor Siegel has just resigned as chairman of the MSMS Medicaid Liaison Committee.



1953.

- General Dwight D. Eisenhower was inaugurated President of the United States; his vice president was Richard M. Nixon.
- The Korean armistice was signed to end the Korean War.
- Not one home owned an electronic calculator or color TV.
- It cost 3¢ to mail a letter.
- The Studebaker was the "new American car with the European look."
- Jacqueline Bouvier was engaged to U.S. Senator John F. Kennedy; **and**
- **the Stratton Agency began serving the Michigan State Medical Society!**

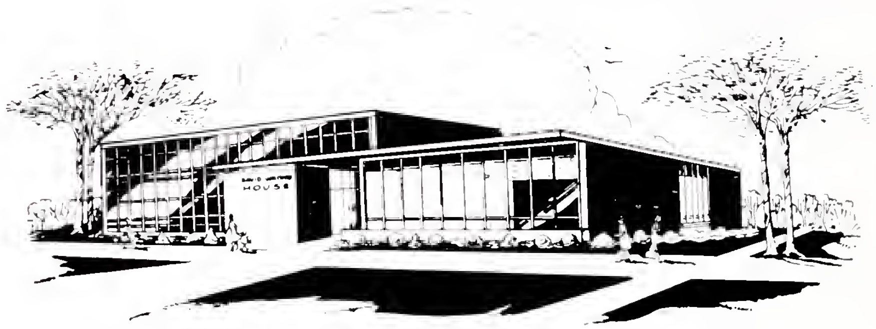
We have appreciated your participation and support over the past 27 years. If you would like additional information about our services, we would be happy to hear from you.

STRATTON-CHEESEMAN & ASSOCIATES, INC.
1305 Abbott Road, P.O. Box 1563
East Lansing, Michigan 48823

800-292-1966

Wayne County Medical Society pleased so fa with its geographic, hospital staff focus

By Dwight Angell, special to Michigan Medicine



Entirely new methods by which representatives of the Wayne County Medical Society are elected became effective last June.

So far, all indications point to its success.

The massive changes, along with the impending results, are so unique that the American Medical Association is keeping close tabs.

The society, the largest in the state, with 3,500 members (3,000 are voting members) and one of the largest in the country, has set up a system that, in essence, parallels the changes in medicine in the last 20 years: it has become more responsive to the needs of physicians, and it has acknowledged the importance of the hospital as the focal point for today's physicians.

The changes to the society's bylaws were passed in April 1979, and the new method of electing officials took place earlier this year. The amendments are the work of two committees: the Planning and Priorities Committee, headed by Frank B. Walker, MD, and the Bylaws Committee, headed by Robert B. Allaben, MD.

In order to appreciate the significance of the changes made by the medical society, a quick review of the society's old methods for electing officials is necessary.

The Council — the governing body of the county society — was elected by the membership at large, as were delegates to the Michigan State Medical Society. But nominations came from a separate nominating committee. So, explains, Roger F. Mecum, executive director of the society, "It was very hard for an MD out there to really get on the ballot unless he or she had been somewhat active for a long time in the society."

New arrangement

Under the new arrangement, the membership at large elects a delegate body which, in turn, elects the Council. But to open up the nominating process, any member can place himself on the nominating ballot. And about one-half of the delegate body — based on the highest votes — automatically become delegates to MSMS.

After that feature was accepted by the planning committee, the next question, says Mecum, was "How can this delegate body be meaningful to our membership?"

It was decided that the delegate body would be composed of phy
cians elected not only by geograph
area, but also by hospital affiliatio
based on the ratio of one delegate f
each 25 WCMS members. (Physicia
have the option of voting either
geographic area or by hospital affil
tion.)

Explains Mecum: "Physicia
have become more and more a
filiated with and identified with ho
pitals. Ten or 15 years ago physicia
were very independent of their ho
pitals — felt no great loyalty to t
institution at all. Now social and pr
fessional events are the domain of t
hospitals.

Under the old method, sa
Mecum, most likely a physicia
would not know the name of eve
physician on the ballot; now, b
breaking the election process dow
by hospitals, physicians are mo
likely to know other physicia
within the same hospital and ther
fore "can make a more intellige
choice of whom them want to repr
sent them."

For example, if there are 15
physicians at Harper-Grace Hospita
who are members of WCMS and wa
to vote by hospital affiliation, the
the hospital staff is entitled to ele
six persons to the delegate body. Fo
the geographic areas, the same pri
ciple applies: one delegate for ea
25 WCMS members. WCMS divide
metro Detroit into four areas.

The final result was 121 del
gates to the delegate body, 45 repre
senting hospitals and 76 representin
geographic areas. Sixty-nine will b
delegates to MSMS.

Hospital pivotal

There were a number of reaso
why the society's leadership orig
nally undertook this change in ele
ting representatives, says Mecu
The importance of hospitals in a phy

an's life was, of course, one im-
tant reason.
Another: "There was a growing
areness that the society was a
up of past presidents that nomi-
ed and perpetuated their own, and
ounger member would have to
ock on the door of the medical so-
y for 10 years before ever getting
olved in a decision-making proc-
."
Another reason: because of the
of the society, information flow
difficult to maintain to and from
membership.
"But now we have a large dele-
e body to help direct the society's
rk and, in turn, feed back to the
mbership in their hospital and
graphic constituencies what the
iety is doing.
For example, if we have to deal
h a hospital or need to get infor-
tion out to its staff, I can call a
egate who has a sense of respon-
ility to get on the staff agenda. So
have someone on the inside."
After a year, the new changes
l be reviewed, says Mecum.
"The success will be obvious if
society has more items in its
rk that come from the membership
lf. If the problems and concerns of
membership are more openly dis-
sed, are more openly debated, that
n element of success all by itself."
The first president under the
w representative system is Ken-
h Ray, MD, of Trenton. He be-
ves the changes have a twofold
portance: to provide a broader rep-
entation of the membership and to
rease the attendance at the soci-
's meetings.
"We have been having problems
ting good attendance at our coun-
meetings. I think there was a feel-
that we were not responding to
ne of the needs of our con-
uents. This has improved. The last
ncil meeting, we needed extra
irs.
"We are seeing some new faces,
ne new blood, people with new
as."

HEALTH PLANNING UPDATE

By Dennis Paradis, East Lansing

Reagan team urges competitive strategy

President-elect Reagan's health policy task force made its report to the Reagan transition team in November. The report was presented by task force chairman William Walsh, MD, president of the People to People Health Foundation, Inc. (Project HOPE). The Washington, DC newsletter "Health Services Information," provides details.

The newsletter says that according to task force member Clark Havighurst, professor of law at Duke University, the report talks about the "reverse incentives" in the current health insurance system and the "history of failure" of government regulation.

To reverse these trends, the report recommends a pro-competitive strategy, including:

- Multiple choice of employee insurance plans.
- Mandatory catastrophic coverage.
- Tax-free rebates to those who choose low-cost coverage.
- Free choice of insurance plans by Medicare recipients.
- A voucher system to pay for coverage for indigents.
- State insurance pool for the uninsurable.

Alain Enthoven, professor at Stanford University and task force member, indicated that there were some issues the task force could not agree on. Most prominent was the question of whether every reimbursement plan should have a uniform basic benefit package. Some task force members favor the uniform benefit package to prevent adverse risk selection from harming comprehensive plans. Other task force members favor a more pluralistic arrangement, believing that innovative approaches will evolve if the marketplace is not stifled by mandatory benefit packages.

The issue of government reimbursement programs under a competitive model was also discussed. While it was conceded that competition could increase the efficiency of the health care delivery system, and thereby lower costs, it was also acknowledged that a competitive model would prevent the subsidization of Medicaid and Medicare patients by other third party reimbursers. The net effect may be to increase the percent of the health care bill paid by government.

The responsibility for health care cost was another area of non-agreement. Havighurst predicted that rising health care costs would no longer be the problem of government, but rather of the private sector. Enthoven feels the Reagan administration will be under intense pressure to slow all domestic spending, including health care spending.

Mr. Paradis is director, MSMS Physician/HSA Support Center.

MDPAC earns good batting average in 1980 general elections

By Thomas C. Payne, MD, Lansing

BALLOT
BALLOT
BALLOT
BALLOT

Blue Pencil sketch

A funny thing happened on the way to the polls — a Republican resurgence.

For the first time in 26 years, Republicans gained control of the United States Senate. By winning 12 seats, Republicans now hold 53 seats to the Democrat's 46. Democrats have dominated congress for so long that only two Republicans, Senator Barry Goldwater, 71, and Congressman John Rhodes, 64, have ever served in a majority status.

The Republican victory toppled most of the Senate's leading Democratic liberals; George McGovern in South Dakota, Frank Church in Idaho, Birch Bayh in Indiana, John Oliver in Iowa, Warren Magnuson in Washington, Gaylord Nelson in Wisconsin and John Durkin in New Hampshire.

In the US House, the Democratic majority was substantially narrowed. Although at least 26 incumbent Democrats were defeated and the Republicans had a net gain of 32 seats, the final breakdown of the 97th Congress will be 243 Democrats and 192 Republicans. While House Speaker Tip O'Neill and majority leader Jim Wright beat back challengers, the third man in the Democratic hierarchy, Whip John Brademas of Indiana lost his bid for a 12th term to businessman John Hiler.

In the Michigan elections, change was not as dramatic. Sixteen of Michigan's incumbent congressmen were returned to office with only three-term incumbent M. Robert Carr (D-East Lansing) actually defeated. Builder James Dunn (R-East Lansing) pulled off the biggest upset of the 1980 election in Michigan by defeating heavily-favored Carr in the 6th District.

George Crockett (D) won the 13th Congressional District seat, replacing Charles Diggs.

Democrat Dennis Hertel, presently a member of the Michigan House, won a seat in the 14th Congressional District. This seat had been vacated by retiring Lucien Nedzi (D-Detroit).

In the Michigan House of Representatives, the Republicans gained seven seats, while losing only one incumbent. The composition of the state legislature is now 64 Democrats to 46 Republicans. Incumbent Democrats defeated by GOP opponents were Reps. Larry Burkhalter, Lapeer; Alice Tomboulian, Rochester; Kenneth DeBeaussaert, Washington; Jeff Dongvillo, Scottville; Charlie Harrison, Jr., Pontiac, and Sal Rocca, Sterling Heights. Republicans replacing them, respectively, are John Strand, 78th District, Lapeer; Mat Dunaskiss, 61st District, Lake Orion; Kirby Holmes, 26th District, Utica; Ed Giese, 98th District, Reed City; L. Jean Willoughby, 55th District, Bloomfield Hills, and Doug Cruce, 71st District, Troy. Rep. Willoughby is the wife of William A. Willoughby, MD, Bloomfield Hills ophthalmologist.

Democrats also lost the Michigan House seat of retiring Gerrit Hasper of Muskegon. The only Democratic gain came when former State Senator John Otterbacher defeated Gran Rapids incumbent Drew Allbritten.

MDPAC results

Michigan Doctors Political Action Committee (MDPAC) in conjunction with the American Medica Political Action Committee (AMPAC was involved financially in 16 of th 19 US House races. Our selecte candidates were successful in 12 o these 16 races — good for a battin average of .750.

In the Michigan House, MDPA divided the races into four categories

1. **Open Seats** — where an incumbent was not running. As incumbents ran in 101 of the 110 seats there were only nine "open seats.' MDPAC made campaign contributions in eight of those races and wa on the winning side six times.

2. **Target seats** — where a satisfactory candidate is opposing an incumbent who we find unsatisfactory MDPAC was successful in all four o the races it contributed to. Anothe race came out to our satisfaction eve though we didn't contribute.

3. **Seats to save** — are seats hel by responsible incumbent legislator sympathetic to physicians' view who are up against a challenger unsatisfactory to MDPAC. MDPAC supported seven such incumbents an was on the winning side six times.

4. **Positive legislative seats** — are those held by responsible legislators with no serious challenge b the opposition party. MDPAC gav support and was successful in all 44.

In all, MDPAC gave to 63 candidates in both the primary and general elections.

MDPAC's final batting average i Michigan House races was .950, wit 60 wins in 63 races.

Future

MDPAC is now looking towards the 1982 election. In that year the Michigan electorate will choose a governor, a US Senator, 19 US Congressmen, 38 state senators and 110 state representatives.

We ask physicians across the state to help medicine in general by becoming active participants in at least one of these races and by becoming a member of MDPAC.

The future of medicine depends heavily upon physician's commitment to political activity.

Doctor Payne is chairman, Michigan Doctors Political Action Committee.

easy to take

DISTA
KEFLEX
250 mg

250-mg Pulvules®

Oral Suspension
250 mg/5 ml
100 and 200-ml sizes

125 mg/5 ml
60, 100, and 200-ml sizes

Pediatric Drops
100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

NEWS

By Bonnie L. Groff, MSMS staff

Benson

Brown

Humes

Laban

Eli M. Brown, MD, Detroit, is the new president of the American Society of Anesthesiologists. . . . **Myron M. LaBan, MD,** Royal Oak, was recently elected to the Board of Governors of the American Academy of Physical Medicine and Rehabilitation. . . . A number of Michigan physicians appointed by the AMA Board of Trustees to AMA committees include: **Robert L. Tupper, MD,** Grand Rapids, Committee on Accreditation of Continuing Medical Education; **James J. Humes, MD,** Detroit, Committee on Allied Health Education and Accreditation; **Robert B. Carbeck, MD,** Ann Arbor, chairman, Advisory Committee on Continuing Medical Education; **Clarence S. Livingood, MD,** Detroit, Liaison Committee on Graduate Medical Education, and **E. James Potchen, MD,** East Lansing, Liaison Committee on Medical Education. Additional appointments to the AMA Council on Medical Education Task Forces are: **Doctor Potchen,** East Lansing, **W. Donald Weston, MD,** East Lansing, **Mohammad N. Akhter, MD,** East Lansing, and **Kenneth Krabbenhoft, MD,** Detroit. Other appointments by the AMA Board of Trustees include: **Doctor Potchen,** East Lansing, American Board of Radiology; **Robert Pool, Jr., MD,** Birmingham, Residency Review Committee (Plastic Surgery), and **Jeremiah G. Turcotte, MD,** Ann Arbor, Residency Review Committee (Surgery). . . . New president-elect of the American College of Emergency Physicians is **B. Ken Gray, MD,** Bloomfield Hills. . . . **Clifford D. Benson, MD,** Grosse Pointe, is recipient of the American Academy of Pediatrics' William E. Ladd Award for outstanding clinical contributions to the field of pediatric surgery during his 44 years of surgical practice. . . . Appointed to the new position of director of administrative and financial affairs at the University of Michigan Medical School is **David J. Bachrach,** Ann Arbor. The position was created to consolidate all financial affairs of the Medical School into one office. . . . New officers of the Michigan Society of Therapeutic Radiologists are: **James R. Dolan, MD,** Kalamazoo, chairman of the board; **Joel E. White, MD,** Detroit, president, and **William E. Powers, MD,** Detroit, president-elect. . . . **Dominic K. H. Wong, MD,** Detroit, is the new president of the Detroit Gastroenterology Society. . . . **Vainutis K. Vaitkevicius, MD,** Pleasant Ridge, is one of two professors honored by the Wayne State University Alumni Association with Faculty Service Awards for exceptional service to the university. Doctor Vaitkevicius was recognized for 20 years of effort in the development of cancer research education and for leadership in developing the WSU-Harper-Grace Hospital medical oncology clinical service center into one of the largest and most respected facilities of its kind. . . . New president of the Michigan Association of Neurological Surgeons is **David A. Herz, MD,** Grand Rapids. . . . The National Medical Fellowships' 1980 Franklin C. McLean Scholar is **Keith Black,** student, University of Michigan Medical School. The award is given annually to a senior who has demonstrated "outstanding academic achievement in medical school and potential for distinguished contributions to the field of medicine.". . . New president of the Central Association of Obstetricians and Gynecologists is **David G. Anderson, MD,** Iron Mountain. . . . The American Societ of Clinical Pathologists and the Co lege of American Pathologists presented their annual Distinguishe Service Award to **James J. Hume MD,** Detroit, at their joint fall mee ing. . . . The Arthritis Foundatio Michigan Chapter, honored **James Lightbody, MD,** Grosse Point Woods, at a reception and dinne meeting. Doctor Lightbody was cite for his longtime service as medica director of the chapter. . . . **Raymon Hockstad, MD,** Escanaba, is ne president of the U.P. Chapter of th American Academy of Family Practice. . . . New president of the U.P Medical Society is **Ali Sawaf, MD** Escanaba. . . . The University o Michigan Medical Center Alumn Society have honored **H. Marvin Pollard, MD,** Ann Arbor, with its Distinguished Alumni Award. Doctor Pollard received the award for service t the society and to the profession o medicine. . . . President of the newl formed Association of Philippin Ophthalmologists in America, Inc., i **Jaime V. Aragones, MD,** Rochester . . . **Andrew D. Hunt, MD,** East Lansing, will begin a one-year consultantship July 1, 1981 as professor an as coordinator of the medica humanities program at Michiga State University. Doctor Hunt als will serve as consultant to the Offic of the Provost. . . . Recipient of Michigan International Council Award is **H.C. Tien, MD,** Lansing psychiatrist and founder of the Worl Journal for the exchange of international literature. Doctor Tien brought the Chinese and American Psychiatric Associations together in 1978. . . Appointed by Governor Milliken t the Mental Health Advisory Council for a term expiring October 30, 1981, is **Jerold R. Harwood, MD,** Traverse City. Doctor Harwood succeeds **Dean P. Carron, MD,** Ann Arbor, who resigned. . . . Volume 28, Number 2 of the Henry Ford Hospital Medical Journal is named the **Richard W. Smith, Jr., MD,** Testimonial Issue. Doctor Smith was fourth chairman of the Department of Medicine of Henry Ford Hospital until his retirement from that position in October 1979.

In G.I. therapy

Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer*
and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function Paradoxical reactions reported in psychiatric patients: Employ usual precautions in treating anxiety states with evidence of impending depression suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances Also encountered. isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®
Roche Products, Inc
Manati, Puerto Rico 00701

Acute pain is no laughing matter.

The first prescription for the first days of acute pain Empirin® c̄ Codeine #3

Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). Ⓒ III

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin c̄ Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin c̄ Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with…two tablets of Empirin c̄ Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No 3 — 30 mg, and No. 4 — 60 mg (Warning — may be habit-forming.) Ⓒ III

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

EETINGS

MS, MSMS/A, AMA d medical assistants

. 17-24 — MSMS/Intrav West In- Air/Sea Cruise, contact: Marce- Ireland, MSMS headquarters. /337-1351.

. 21 — MSMS Council, MSMS dquarters, contact: Warren F. loff, MSMS headquarters.

. 24 — AMA 22nd National Con- nce on the Medical Aspects of rts, Atlanta Hilton, contact: Jack l, AMA, 535 N. Dearborn, cago, 60610.

. 24-26 — AMA Winter Scientific eting, Atlanta Hilton, contact: De- tment of Meeting Services, AMA, N. Dearborn, Chicago, 60610.

. 26 — MSMS/A Mid-year Board eting, MSMS headquarters, con- : Caroline Rich, MSMS headquar-

. 31-Feb. 1 — Mid-Winter Semi- , State of Michigan Branch, erican Association of Medical As- tants, Benton Harbor, contact: oline Rich, MSMS headquarters.

. 10-11 — Practice Management ninar, MSMS/Physician Service up, Inc., Long's Convention ter, Lansing, contact: Meredith s, MSMS headquarters.

. 12-13 — Practice Management ninar, MSMS/Physician Service up, Inc., Michigan Inn, South- d, contact: Meredith Fors, MSMS dquarters.

. 12-14 — 1981 AMA National dership Conference, Marriott tel, Chicago, contact: Linda Hud- , AMA headquarters, 312/751- 6.

. 20-Mar. 7 — MSMS/Intrav South ican Adventure, contact: Marce- Ireland, MSMS headquarters. /337-1351.

r. 11 — MSMS Council, MSMS dquarters, contact: Warren F. loff, MSMS headquarters.

r. 11 — MSMS/A Legislative Day, ic Center, Lansing, contact: oline Rich, MSMS headquarters.

r. 25-26 — MSMS Conference on ternal and Perinatal Health, Hyatt gency Dearborn, contact: Katie wbaker, MSMS headquarters.

Apr. 9 — MSMS Conference on Sports Medicine, Western Michigan University Student Center, Kalamazoo, contact: Mert Scholten, MSMS headquarters.

Apr. 23-26 — Annual meeting, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn, Lansing, contact: Caroline Rich, MSMS headquarters.

Apr. 27-29 — 55th annual convention, MSMS/A, Marriott Inn, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

May 1-3 — MSMS House of Delegates, Troy Hilton, contact: Richard Campau, MSMS headquarters.

Sept. 9 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Oct. 21 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren F Tryloff, MSMS headquarters.

Other meetings

Jan. 16 — Annual membership meeting, Michigan Ophthalmological Society, Wayne County Medical Society headquarters, Detroit, contact: Margot Surridge, Executive Secretary, MOS, 313-839-3011.

Jan. 22 — Council meeting, Michigan Psychiatric Society, Hyatt Regency Dearborn, contact: Helen Schulte, MSMS headquarters.

Feb. 11 — Membership meeting, Michigan Dermatological Society, Henry Ford Hospital, Detroit, contact: Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067.

Feb. 26 — Council meeting, Michigan Psychiatric Society, Marriott Inn, Ann Arbor, contact: Helen Schulte, MSMS headquarters.

Mar. 11 — Membership meeting, Michigan Dermatological Society, Wayne State University, Detroit, contact: Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067.

Mar. 14-15 — Regional Conference on the Impaired Professional, Hilton Inn North, Worthington, OH, contact: Marcelyn Ireland, MSMS headquarters.

Apr. 23 — Council Meeting, Michigan Psychiatric Society, Detroit, contact: Helen Schulte, MSMS headquarters.

Apr. 30 — Annual Meeting, Michigan Society of Thoracic Surgeons, Hyatt Regency Dearborn, contact: Rodman E. Taber, MD, 30050 Hoover Road, Warren, 48093.

May 26-28 — 60th Annual Conference, Michigan Public Health Association, Sheraton Southfield Hotel, contact: MPHA, 1407 S. Harrison, Suite 340, East Lansing, 48823.

July 29-30 — 24th Annual Congress of Delegates meeting, Michigan Academy of Family Physicians, Holiday Inn, Traverse City, contact: Loretta Joyce, Executive Director, MAFP, 416 N. Homer, Suite 107, Lansing, 48912.

Aug. 28-30 — Summer meeting, Michigan Psychiatric Society, Holiday Inn, Traverse City, contact: Helen Schulte, MSMS headquarters.

STAT MEDICAL BOOKS

The discount book store

- New Medical Texts and References
- Diagnostic Instruments and Supplies
- School Supplies
- Fast "Special Order" Service
- Shop by Phone or Mail
- Every Book and Medical Supply Discounted

IN ADDITION:

- Sit-Down Reading Accommodations
- Conveniently Located in:
  5030 Northwind Farms
  East Lansing, MI 48823

Across from Coral Gables

- Telephone (517) 351-2610
- Hours: Mon-Wed 10:00-6:00
  Thurs. 10:00-8:00
  Fri. 10:00-6:00
  Sat. 10:00-4:00

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category 1 credit toward meeting the requirements of Michigan law. Sponsors of Category 1 programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category 1 credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Jan. 21, Current Advances in Hepatitis and Liver Diseases. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: Jan. 23-24, Winter meeting — "Times of Crisis." Location: Hyatt Regency Dearborn. **Sponsor:** Michigan Psychiatric Society. **Cost:** $130. **Contact:** Helen Schulte, MPS headquarters. PO Box 950, East Lansing, 48823. **Approved for:** 12 hours of Category I Credit.

Date: Feb. 1-6, Midwinter Family Practice Update. Location: Boyne Highlands, Harbor Springs. **Sponsor:** U-M Office of CME. **For:** All interested physicians. **Contact:** William R. Harlin, MD, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109. **Approved for:** 22 hours of Category I Credit.

Date: Feb. 7, Rheumatology Update. Location: Saginaw Osteopathic Hospital. **Sponsor:** Department of Osteopathic Medicine, Michigan State University. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 6 hours of Category I Credit.

Date: Feb. 12-13, Seminar on Quality Assurance for Psychiatric and Substance Abuse Facilities. Location: Romulus. **Sponsor:** Joint Commission on Accreditation of Hospitals and Michigan Hospital Association. **For:** All interested physicians. **Contact:** Maryanne Butt, Michigan Hospital Association, 2213 E. Grand River, Lansing, 48912. 517/484-7441. **Approved for:** 11 hours of Category I Credit.

Date: Feb. 14, A Practical Endocrinologic Approach for the Diagnosis of Thyroid and Adrenal Disorders. Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **For:** All interested physicians. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI 48236. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 18-19, Problems & Perspectives in Pulmonary Infections. Location: Boyne Highlands. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202, 313/876-1463. A proved for: 7 hours of Category I Credit.

Date: Feb. 20-22, Practical Otolaryngology. l cation: Dearborn Inn, Dearborn. **Spons** Wayne State University Office of CME. **For:** interested physicians. **Contact:** Ms. An Tompkins, 313/577-1180. **Approved for:** hours of Category I Credit.

Date: Feb. 21, Rheumatology Update. Locati Muskegon Osteopathic Hospital. **Sponsor:** I partment of Osteopathic Medicine, Michig State University. **For:** All interested physicia **Contact:** Sandy Kilbourn, Coordinator CM 517/353-8822. **Approved For:** 6 hours of Ca gory I Credit.

Date: Feb. 22-27, Emergencies In Medicine. I cation: Boyne Falls. **Sponsor:** Wayne State U versity School of Medicine. **For:** All interest physicians. **Contact:** Theresa Sokol, WS School of Medicine, Department of Surgery, University Health Center, 4201 St. Antoine, I troit, 48201. **Approved for:** 23 hours of Catego I Credit.

Date: Feb. 23-Mar. 2, St. Thomas Adventu Location: St. Thomas, Virgin Islands. **Spons** Michigan State University College of Oste pathic Medicine Alumni and the MSU Colle of Osteopathic Medicine. **For:** All interest physicians. **Contact:** Sandy Kilbourn, Coc dinator CME, 517/353-8822. **Approved for:** hours of Category I Credit.

Date: March 4, Adolescent Gynecology and O stetrics. Location: St. John Hospital, Detro **Sponsor:** St. John Hospital. **For:** All interest physicians. **Cost:** $100. **Contact:** Ms. Lin Radu, Continuing Medical Education, 313/34 3877. **Approved for:** 8 hours of Category I Cr dit.

continued on page 3

Administrative office and main laboratory

AMRC the full service laboratory

- Complete range of individual tests and diagnostic profiles
- Medical consultation services
- Comprehensive quality control program
- Fully accredited
- Complete billing service

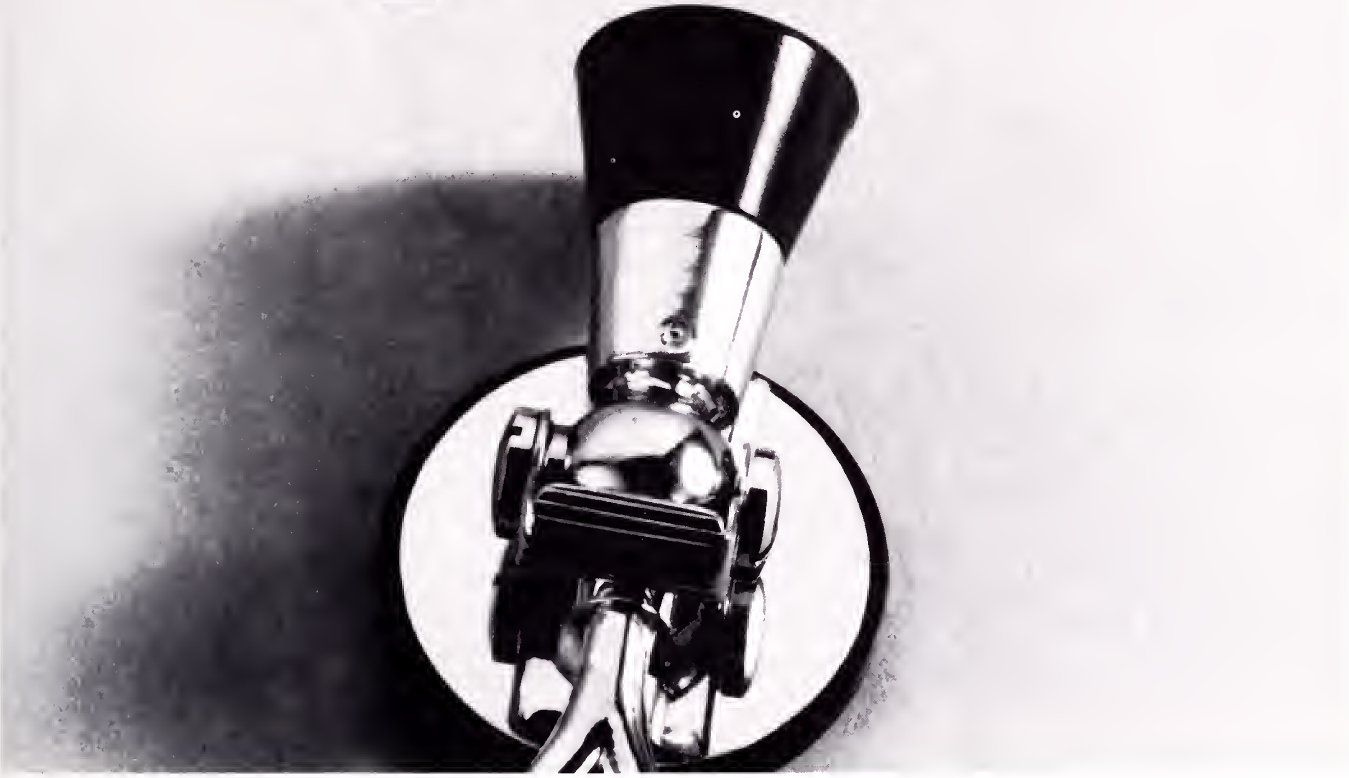
Advance Medical &
Research Center, Inc.

1270 Doris Rd. • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN



Healthy Competition Makes A Healthier Market

Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.

Occurrence Coverage

Choice of limits—$100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

Date: Mar. 8, 3rd Annual Pain Conference, "Stress and Its Effect on Musculoskeletal Pain." Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 7 hours of Category I Credit.

Date: March 12, Seminar on Long Term Care Standards. Location: Troy. **Sponsor:** Joint Commission on Accreditation of Hospitals and Michigan Hospital Association. **For:** All interested physicians. **Contact:** Maryanne Butt, Michigan Hospital Association, 2213 E. Grand River, Lansing, 48912. 517/484-7441. **Approved for:** 7½ hours of Category I Credit.

Date: Mar. 22, 4th Annual Pediatrics Conference. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Department of Pediatrics, Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 7½ hours of Category I Credit.

Date: April 1-4, Aesthetic and Reconstructive Surgery of the Head and Neck. Location: Campus Inn, Ann Arbor. **Sponsor:** Department of Otolaryngology, University of Michigan Medical Center. **For:** All interested physicians. **Cost:** $500. **Contact:** Shan R. Baker, MD, Dept. of Otolaryngology, University of Michigan Medical Center, Ann Arbor, 48109. **Approved for:** 28 hours of Category I Credit.

Date: April 11, Breast Cancer. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 8 hours of Category I Credit.

Date: April 15, Pediatric Seminar V. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22101 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: April 23-25, Critical Care Symposium. Location: Wayne County Medical Society Headquarters. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Theresa Sokol, WSU School of Medicine, Department of Surgery 6C University Health Center, 4201 St. Antoine, Detroit, 48201. **Approved for:** 15 hours of Category I Credit.

Date: April 25-29, Advanced Muscle Energy Tutorial. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Date: April 27-29, Echocardiography — State of the Art. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan Heart Association and the American Heart Association Council on Clinical Cardiology. **For:** All interested physicians. **Contact:** Michigan Heart Association, P.O. Box 160-LV, Lathrup Village, 48076. 313/557-9500. **Approved for:** 15 hours of Category I Credit.

Date: May 14, Major Problems in Adolescence. Location: Kalamazoo Hilton. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** $55. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 16-18, Michigan Dermatological Society Central States Meeting. Location: University of Michigan, Ann Arbor. **Sponsor:** Mic gan Dermatological Society. **For:** All dermat ogists. **Contact:** Alejandro Morales, MD, 1 Fernwood, Royal Oak, 48067. **Approved for** hours of Category I Credit.

Date: May 20, Family Practice Update. Lo tion: Saint John Hospital, Detroit. **Spons** Saint John Hospital. **For:** All interested phy cians. **Cost:** $100. **Contact:** Ms. Linda Ra Continuing Medical Education, 313/343-38 **Approved for:** 8 hours of Category I Credit.

Date: June 15-19, Basic Principles of Man Medicine. Location: Kellogg Center, MSU, E Lansing. **Sponsor:** Michigan State Univers College of Osteopathic Medicine. **For:** All terested physicians. **Contact:** Sandy Kilbou Coordinator CME, 517/353-8822. **Approved f** 40 hours of Category I Credit.

Date: June 19-21, Keyport-Gaylord Trau Symposium. Location: Hidden Valley Cl Gaylord. **Sponsor:** Wayne State Univers School of Medicine. **For:** All interested phy cians. **Contact:** Benjamin Henig, MD, Keyp Clinic, 308 Michigan Ave., Grayling, 497 **Approved for:** 12 hours of Category I Credit.

Date: June 19-21, Michigan Dermatological S ciety Annual Meeting. Location: Renaissan Center, Detroit. **Sponsor:** Michigan Dermatol ical Society. **For:** All interested dermatologis **Contact:** Alejandro Morales, MD, 10 Fernwood, Royal Oak, 48067. **Approved for:** hours of Category I Credit.

Date: Aug. 18-21, Michigan Health Offic Association Annual Meeting. Location: Holid Inn, Traverse City. **Sponsor:** Michigan Heal Officers Association. **For:** All interested phy cians and health officers. **Contact:** William Moon, MD, Box 43, Harrietta, 49638. **Approv for:** 5 hours of Category I Credit.

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road   Conducted by Sisters of Mercy   Ann Arbor, Michigan

Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs.

(Active & Associate)

Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Mark S. Fettman, M.D.
Robert L. Fransway, M.D.
Sarath Hemachandra, M.D.
Charles G. Krasnow, M.D.
Carlos M. Lauchu, M.D.
Satya Pasricha, M.D.
Richard E. Pfrender, M.D.
Arcadio V. Ramirez, M.D.
Gerard M. Schmit, M.D.
Bruce D. Schweiger, M.D.
Joseph J. Tiziani, M.D.
Dushyant Trivedi, M.D.
Prelad S. Vachher, M.D.
Angela Wallenbrock, M.D.
Denis Walsh, M.D.
Robert M. Zimmerman, M.D.

"EVERY AGE HAS ITS PLEASURES, ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

PAVABID® AND PAVABID® HP
(papaverine hydrochloride)
150-mg Capsules 300-mg Capsulets

Patient benefit products from

PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY MO 64137

6/80

DEATHS

Joseph Bertucci, MD
Ishpeming

Joseph P. Bertucci, MD, Ishpeming, died Oct. 15 at the age of 79. Doctor Bertucci received his MD from Marquette University Medical School in 1932. In 1977 he served as chief of staff at the F.A. Bell Memorial Hospital. He was a fellow of the American College of Cardiology and a member of the board of directors of the Acocks Medical Care Facility.

Paul E. Medema, MD
Muskegon

Paul E. Medema, MD, Muskegon, died Oct. 12. He was 81. Doctor Medema served as chief of staff at Hackley Hospital from 1957 to 1960 and as chief of surgery from 1954 to 1957. He earned his MD in 1929 from Marquette University Medical School. Doctor Medema maintained a private practice in Muskegon from 1929 until his retirement in 1978.

Robert P. Richardson, MD
St. Clair

Robert P. Richardson, MD, St. Clair, died Nov. 10 at the age of 56. Doctor Richardson maintained a pediatric practice in the Detroit area since 1952. He received his MD from Wayne State University School of Medicine in 1948. During the Korean War he served as a medical officer with the Navy in the Pacific. He was a member of the American Academy of Pediatrics and the Detroit Pediatric Society.

Aaron Z. Rogers, MD
Marietta, GA

Aaron Z. Rogers, MD, Marietta, GA, died Aug. 16. He was 77. He earned his MD in 1930 from Wayne State University School of Medicine. Doctor Rogers began his practice in the Detroit area in 1931. He was past president of the staff at Cottage Hospital and served as clinical assistant in surgery. In 1956 he was pre
dent of the Wayne County Acader
of General Practice.

George A. Sherman, MD
East Lansing

George A. Sherman, MD, East La
sing, died Oct 28 at the age of
Doctor Sherman received his MD
1924 from McGill University Medi
School in Montreal. From 1941
1947 he served as director of tub
culosis control for the state of Mic
gan. He was past president of t
Ingham County Medical Society a
the Oakland County Medical Socie

William L. Shields, MD
Jacksonville Beach, FL

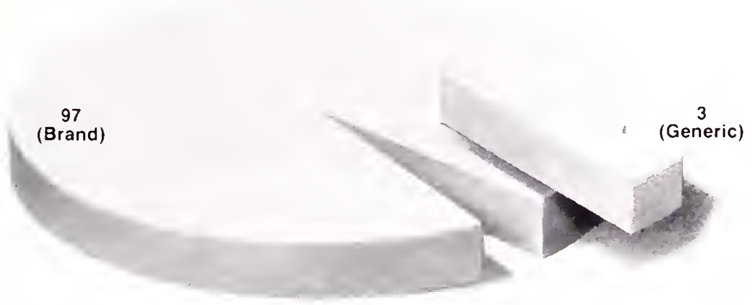
William L. Shields, MD, Jacksonvi
Beach, FL, died Oct. 25. He was
Doctor Shields served as chief
medical services for 35 years
Chrysler Corporation's Highland P

continued on page

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
Since 1899
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

DETROIT OFFICE
R. K. Wind, J. K. Galloway, T. A. Weisman, and W. M. Bockus, Representatives
6785 Telegraph Road, Suite 350, Birmingham 48010
Telephone (313) 647-6640
GRAND RAPIDS OFFICE: G. J. Haworth, Representative
143 Cortland Avenue, Rockford 49341, Telephone (616) 866-9395

Is there a generic equivalent for drug research?



Estimated Drug Industry Investment in R&D*

Frankly, the dollars say no.

By the most generous estimates, generic manufacturers contribute barely 3% of the more than one billion dollars spent annually in the laboratories of American drug firms on research and development of new drugs.

For the last quarter of a century, virtually all of the major new drugs that imitators imitate have originated with a handful of research-oriented firms well known to all.

While our national investment in research has been declining steadily for a decade, the American pharmaceutical industry has actually been increasing its commitment, so that it now spends over five times the national average. No other industry dedicates a higher percentage of its profits to research. No industry in America depends less on government subsidies.

In the last two decades, the cost of introducing a significant new drug has risen from roughly $4,000,000 to over $50,000,000, while its effective patent life has eroded from seventeen years to less than ten.

Today, the entire research and development commitment of ALL generic manufacturers combined is not enough to develop one single new drug entity.

When you prescribe generics, you switch profits from the innovators to the imitators...and R&D rarely appears on the imitators' budget sheets. Meanwhile, there are *real* people who may have to suffer and perhaps die needlessly if the incentives to progress are removed. It would be sad to abandon our commitment to the future in the short-sighted search for a bargain.

*Based on 1977 published figures available from National Science Foundation and or Pharmaceutical Manufacturers Association

ROCHE®

Without the innovators, there could be no imitators

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

MICHIGAN HEALTH DIRECTOR — If you are a health administrator seeking a challenging role in public health in the eighties, consider placing your application for the post of Director of Public Health for the State of Michigan. Requires eight years administrative experience, including five in the health field, or a health-related master's degree and five years of health administrative experience. Appointment by the Governor of Michigan. Salary competitive within the field. A challenging post — leading a scientific staff of the fifth oldest state health agency in the nation — innovating in the implementation of Michigan's landmark public health code passed in 1978. Send your application or inquiry to: Governor William G. Milliken, State of Michigan, State Capitol Building, Lansing, Michigan, 48909. An Equal Opportunity-Affirmative Action Employer.

(Medical) Specialist — Ob-Gyn or Other. Grosse Pointe Area, five room suite. Other tenants are family practice clinic and radiologist with ultrasound, fluoroscopy and nuclear medicine. Full maintenance with janitorial service. $500.00 per month. 16840 E. Warren — Steven at (313) 882-7060.

Lovely Southwestern Climate — Multispecialty group seeking anesthesiologist. Substantial guarantee. Contact Talton L. Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, TX, 79925. Phone 915/592-0201.

Lovely Southwestern Climate — Multispecialty group seeking Obg physician. Substantial guarantee. Contact Talton L. Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, TX, 79925. Phone 915/592-0201.

Board certified physician interested in group practice in a rapidly growing community in southeastern Michigan, affiliated with a 595-bed community teaching hospital. Should have 3 to 5 years practice experience. Four positions available. Send curriculum vitae to: President's Office, Oakwood Hospital, 18101 Oakwood Blvd., Dearborn, Michigan 48124.

The Board of Health, Marquette County, Michigan, is accepting applications for the position of Health Officer/Medical Director, requirements for the position are certification in preventive medicine or public health; or MPH or MSPH degree and not less than 2 years of full-time public health practice; or not less than 3 years of full-time public health practice and 24 graduate credits acceptable toward public health degree; and license to practice in Michigan. Salary $50,000 per year but negotiable according to qualifications and experience; liberal fringe benefits. The Marquette County Health Department is a single county department located in Michigan's beautiful Upper Peninsula which features a wide range of year-round outdoor activities; excellent living conditions. Send curriculum vitae to: Chairman, Marquette County Board of Health, 184 U.S. 41 Highway, Negaunee, Michigan 49866, prior to February 15, 1981. An Equal Opportunity Employer.

Clinical Cardiology Fellow wanted for outpatient and inpatient clinical care and clinical research in cardiology. Requires MD degree, 2 years residency in internal medicine. Salary $20,466.00 per year, 40 hours per week. Contact: B. Pitt, MD, University of Michigan Department of Medicine, 1405 E. Ann Street, Ann Arbor, Michigan 48109. 313/763-3488. The University of Michigan is an equal opportunity/affirmative action employer.

Pediatrician wanted for diagnosis and treatment of children with variety of childlike diseases and ailments. Requires MD degree, 2 years residency in pediatrics. Salary $36,000 per year, 40 hours per week. Contact: A. Hodari, MD, Hodari & Associates, 690 Mollett, Detroit, Michigan 48226. 313/225-5239.

OB-GYN: Board eligible or certified to join busy practice in a beautiful resort area close to Detroit. Excellent office located one mile from hospital. No investment required. Equal work. Salary open. Partnership available after first of year. M. I. Sabbagh, MD, P.O. Box 163, St. Clair, 48079. 313/329-7000.

MUNSTER, IN. — Family Phys., Gen. Internists, ENT, Orthopaedists, Gen. Surgeons needed for large midwest multi-specialty group. Competitive first year salary with opportunity for early partnership; all fringes clinic paid. Excellent opportunity to inherit existing and develop your own practice. Call or send CV to: T. R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN. 46321. (219) 836-5800.

OBSTETRICIAN/GYNECOLOGIST, OPHTHALMOLOGIST, ORTHOPOD, PEDIATRICIAN — needed in historic Marshall, Michigan, located half-way between Ann Arbor and Kalamazoo. Beautiful town with a 77-bed acute care hospital. City population of 7,500 and service area population of 22,000. Admitting staff includes; four (4) Family Practice Specialists, five (5) General Practitioners, two (2) General Surgeons, and one (1) Internist. Willing to negotiate to attract a high caliber physician. Contact: Rob Covert, Administrator, or Philip Glotfelty, MD, Chief of Staff, Oaklawn Hospital, 200 North Madison, Marshall, Michigan 49068; or phone 616-781-4271, extension 201.

GP or FP for new clinic in the beautiful Black Hills. Ideal setting for many outdoor activities and a place to raise healthy children. Hospital with 49 beds, close association with large medical center. Primary care oriented group practice with starting salary $40,000 plus health, life and malpractice insurance. Contact: Chris Lucas, MD, 209 N. 16th St., Hot Springs, SD, 57747. 605/745-3159.

Primary Care Physicians for independent family practice, internal medicine, and pediatrics. North Central Wisconsin. Excellent clinical facilities and assured support of independent practitioners. P.O. Box 801, Neenah, Wisconsin, 54956.

Rheumatologist Wanted — to join four orthopedic surgeons in a very desirable North Central Wisconsin community with a drawing population of 70,000. Active practice assured, share "on call" provided, research grants available. New clinic facility located within new 35 million dollar hospital complex. Outstanding personal benefit programs, generous guaranteed income. For further information contact: Lloyd Engstrom at (715) 842-3202, or write P.O. Box 1646, Wausau, WI 54401.

Urologist — Board certified or eligible to join the staff of J.C.A.H. approved 129-bed hospital in northern Michigan's four season vacati
land. Office available in new attached medi
building. Salary guarantee available. Conta
David H. Spedding, Community Memorial H
pital, 748 South Main Street, Cheboygan,
49721. Phone 1-616-627-5601.

Positions With The State Of Michigan — C
rently taking applications for positions
pected to be available in the future. Prima
interested in board certified or board eligi
internists with cardiology background. Off
locations in Southfield, Lansing, and Trave
City. Also considering an office in Kalamaz
Salary in 50's with approximately 40% frir
benefits. An equal opportunity employer.
inquiries treated confidentially. For further
tails please write: Disability Determinat
Service, P.O. Box 30011, Lansing, MI 48909,
call collect: Harry D. Nesmith, MD, Chief Me
cal Consultant (517) 373-7830. In Michigan,
toll free 1-800-292-2710.

PART-TIME PHYSICIAN needed to do rout
physicals to assess donor suitability
plasmapheresis. Good position for ol
physician looking to slow down. Malpract
coverage provided. Contact Thomas Anders
at American Plasma Management, Kalamaz
MI. Phone 616/381-0086.

LOCUM TENENS — EMERGENCY DEPA
MENT OPENINGS. Our group is serving em
gency departments throughout the cour
with openings for locum tenens physicia
Flexible schedules and attractive locatio
available. Malpractice insurance and comp
tive hourly rates are offered. We're on
move — Come grow with us. Contact E
Suite 115, 1 Windemere Place, Petosk
Michigan 49770. Out of State 1-800-253-70
Michigan 1-616-347-1580.

Positions available in Multi-Specialty Cli
and Emergency Departments throughout
U.S. Guaranteed salary with full benefits. Co
grow with us — We're on the move. Cont
ECI, Recruitment Division, Suite 115, 2240
Airport Rd., Traverse City, MI 49684, or cal
Michigan 1-800-632-3496, Out of State 1-8
253-1795.

Allergy, Cardiovascular Surgery, Dermat
ogy, Gastroenterology, Nephrology, Neurolo
Psychiatry and Associate Director of Fam
Practice Residency Program. Opportunities
solo, small group private practice. Tertiary
ferral center with active teaching program a
fully equipped hospital including advanced
facilities, CT scanner, oncology program, c
lab and cardiac surgery, dialysis, etc. Serv
area 300,000 plus. Unspoiled university city
Lake Superior offers outstanding recreatio
opportunities. Contact: John D. Wojcik, M
Chairman of Recruitment Committee, M
quette General Hospital, 906-228-9440, e
434.

GROW WITH US IN SUNNY ARIZONA — T
INA Healthplan needs physicians in fam
practice and most specialties in Tucson a
Phoenix. Competitive salaries and comprehe
sive benefits including a professional c
velopment program, retirement plan, a
group incentive bonus are provided. If team
teraction and casual living interest you, se
your CV to: Professional Relations, II
Healthplan, Inc., 6115 North 7th Stre
Phoenix, AZ 85014.

UNIVERSITY HEALTH SERVICES — MICI
GAN TECHNOLOGICAL UNIVERSITY Hea
service seeks a replacement primary care me
ical director. The health facility is a medica
oriented, ambulatory service, servicing a u
versity student population of 7,700. Annu

nts visits are approximately 10,000. Lib-
ringe, meeting allowance, and vacation
its complement a competitive salary and
adequate enjoyment of the rural all-
n recreation area. Contact Terry Kinzel,
MTU Health Services, Houghton, MI
1. Phone 906-487-2435. Michigan
nological University is an equal opportu-
educational institution/equal opportunity
oyer.

yn practice open in Mt. Clemens area.
ent incumbent retiring when suitable,
ied applicant applies to take over office.
O.W. Oughtred, MD, F.A.C.O.G., 35992
Gratiot, Mt. Clemens, 48043.

sitions wanted

gic Surgeon seeks practice opportunity
est Michigan, solo or group. University
d, board certified, 5 yrs. solo practice.
ously board certified anesthesiologist.
ican, University of Michigan graduate
christian, married 24 yrs., 5 children.
rd M. Delnay, MD, 1646 Sam Houston Dr.,
gen, TX, 78550.

scellaneous

ABLE RIVER-FRONT HOME. Year around
at. Prime trout fishing out your front door.
e acres with private trout pond. Enjoy
ace on cold days — Watch river drift by
cozy glassed-in living room. Completely
shed. Eight miles east of Grayling. Price
00. Terms available. Call Ruth Steffe,
ury 21 River Country, 517/348-9868.

lair Michigan — Modern medical office,
hospital, 1200 sq. ft., available January
. Good growth location and pleasant liv-
Ample parking. Reasonable rent. Call M. I.
agh, MD, 1-313-329-7000.

Medical-Dental Building. 11,000 square
Orchard Lake Road in West Bloomfield.
626-4600.

amp ultraviolet black light treatment box
six extra light tubes. 216/964-8592.

Colorado, available after January 5, 1981,
three bedroom, 2½ bath condominium.
os eight comfortably. Call Bob 334-6100.

ors Office — Inexpensive sub-lease in
ping center. 1300 sq. ft., waiting room,
ness office, lab and 6 exam rooms. Ideal
or 2 physicians. Excellent location and
ing. Dennis Burke, MD, 2528 Packard, Ann
r, MI., 48104. ph. 313-973-9044.

ell, Michigan — 8,000 sq. ft., medical-den-
vailable January, 1981, in attractively de-
ed professional building. Complex conven-
y located within walking distance of hospi-
which serves fastest growing county in
. For information, call evenings, 517/546-
.

CE FURNITURE. Superb designer's selec-
Custom-to-order from solid teak,
wood, mahogany and walnut. Catalog on
est. Detroit Woodworking Co., telephone:
332-6721.

ON HEAD ISLAND. 2 br, 2 br luxurious,
nfront condominium. Sleeps six, fully fur-
ed and equipped. Free, unlimited tennis,
nearby, private beach, pool. Available April
ay 2. Call 517/393-7730 evenings.

ida Hutchinson Island. South of Vero
ch. Luxurious vacation condos directly on
ate ocean front beach. Completely fur-
ed including cable TV, stereo and telephone. Pool, tennis, game room, etc. Minimum 1 month rental. 1 bedroom unit — $1,200 per mo. 2 bedroom unit — $1,400 per mo. Call 313/882-4900 or 751-5588.

Michigan delegates to the AMA were part of a recent series of home-town interviews arranged during an AMA House of Delegates meeting. The interviews, which focused on the impact of inflation and unemployment on the patient's ability to pay for medical care, on cost containment, preventive medicine, primary care trends, and the impaired physician, were distributed within 24 hours to radio stations in the physician's home town. Michigan delegates above are Robert D. Burton, MD, Grand Rapids, left, and Thomas R. Berglund, MD, Kalamazoo.

INVESTMENTS: What tangible asset has returned over 40% per year compounded annually since 1972? Learn about rare coin investing, the prudent investment opportunity for KEOGH, IRA, profit sharing plans. Your hedge against inflation. Write for free investment brochure. John Frank Rare Coin Investments LTD., 3000 Town Center, Suite 1444, Southfield, MI 48033. 313-354-3666.

Medical Professional Office, Lansing, Michigan. Corner of Pennsylvania and May streets. Site plan approved by the city of Lansing for 3,600 square foot professional building. Conceptual plans done. Ready to apply your interior layout and construct to suit. Will build to lease to your specifications. Ideal location between Saginaw and Oakland in developing area six blocks from Sparrow Hospital. Purchase possible. Also 10,000 square feet of new office across from Delta Dental in Okemos, construction starting soon, 5,000 feet still available in this outstanding building. Others coming on with condominium purchase possible. Contact C. Wallin 517/349-0461.

Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury, two & three bedroom units. Near Boyne ski hills. $92,000-$96,500. Furnished unit rentals available for vacation year round. A.K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

St. Thomas, U.S.V.I. Ocean front condominium villa. Sleeps 4-6. Three pools, free tennis, duty free shopping. List of local medical meetings available. Reduced air fares. 313/543-2970 or 542-7600.

St. Thomas, U.S.V.I. Condominium For Rent. Ocean Front. Two bedrooms, two baths, free tennis, three pools. Duty free shopping. List of medical meetings available. 313/543-2970 or 313/542-7600.

Hilton Head Island, SC. Ocean Villa, Captain's Cove in Palmetto Dunes Resort. Luxurious new villa, 150 yds. from beach. Lagoon backyard, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, pool fishing, canoeing, biking, etc. Weekly, monthly. Call or write, 313/695-0356, 6236 Kings Crown Rd., Grand Blanc, MI 48439.

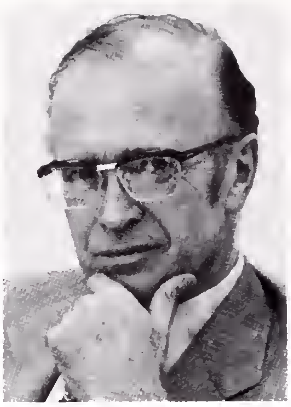
We have various quantities of medical equipment available in excellent condition. We buy, sell, trade, move. New equipment also available. Call Doctor Medical Resale, 313-569-4407, 9 am to 9 pm.

DEATHS/*continued*

headquarters. He earned his MD from the University of Toronto Medical College in 1923. He was past president of the Detroit Industrial Medical Association.

Clarence A. Vandervelde, MD
Muskegon

Clarence A. Vandervelde, MD, Muskegon, died Nov. 8 at the age of 59. Doctor Vandervelde received his MD from Marquette University Medical School in 1946. He served as past president of the Muskegon County Medical Society and chief of staff at Hackley Hospital. He was a member of the Detroit Branch of the American Urological Society and the North Central Section of the American Urological Society.



PRESIDENT'S PAGE

The system can be changed

By John R. Ylvisaker, MD, MSMS President

Previous essays have developed the theme that there are virtually no arguments based on economics, human behavior, or professionalism which justify the full service benefit (first-dollar coverage) form of reimbursement for health care services. However, there are known old and new insurance plans which demonstrate that health care can be delivered at lower cost without rationing or regulation.

Ideally, such insurance coverages should address the issues of quality, access, and cost. They should make both patient and physician constantly cost-conscious in the decisions of whether care is needed, how much care is needed, and where care can best be provided. They must leave intact the rights of free choice, allow and rely on high standards of professionalism, and rely on the basic integrity of the patient and physician in their relationship. Since we object to both rationing and over-utilization of care, most of us strongly feel there should be a significant first-dollar responsibility placed on the patient.

Alternative plans depend on varying applications of conventional insurance mechanisms for coverage but introduce "incentives" for the consumer and provider to be more cost-conscious. These mechanisms primarily are full service benefit (full payment for all defined services), co-payment, and deductible (high, low, or a combination).

Three general approaches

The following summary of three general approaches is only to establish that there are different and better ways to do business. Each, however, requires detailed study and careful application.

1) HMOs (a bad word to many physicians) — HMOs provide broad coverage of office and hospital care, usually full-service benefit but often with deductible or co-pay features. Patient incentives for cost-consciousness are low total out-of-pocket cost with premiums controlled by favorable experience of usage. Provider incentives range from security of practice volume and income to control of standards and patterns of care.

In established, efficiently-run HMOs, repeated studies have shown cost savings of 10-40 percent, reduction of hospital usage by up to 50 percent or more, and clinical outcome equal to any comparable practice arrangement.

Group and staff models have been around for years but are not popular with many physicians.

The "alliance" form is new and growing rapidly. IPAs are the best example. They allow physicians to practice in their own offices and retain all the flexibility of private practice as long as care and fees meet reasonable standards.

2) Staged deductible plans — A number of industries use a combined low and high deductible approach: initial low deductible ($100-200), then full coverage to a second level (e.g. $3,000), a larger deductible (e.g $500), and then full coverage. The premiums are low and there is a staged "first dollar" deterrent to injudicious use, but limited risk for out-of-pocket cost.

3) "Savings" plans — These are little-known but are rapidly gaining visibility and interest. Basically, they are high deductible plans ($500 to $1,000) with low premiums but with self-insurance of the deductible portion paid out of premium savings. Residual savings generated by low premiums accrues to each subscriber.

A Mendocino, California, scho
district sets aside the difference b
tween cost of conventional premium
and the new low premiums (abo
$500 annually) first to self-insure th
deductible and next to accrue th
balance cumulatively for pay-out
the subscriber at termination of em
ployment.

The Louisiana State Medical S
ciety has a CHIP (consumer healt
investment plan) — high deductib
savings available as self-insurance f
the deductible; surplus retained f
savings or investment.

Richard Straith, MD, Detroit
proposed a high deductible pla
which would pool the premium do
lars saved within the first one-an
a-half years in a loan fund to cov
deductible costs, but then woul
lower the annual premiums as i
"savings" feature.

Walter McClure of InterStud
recommends annual tax-free return
surplus savings to the subscribe
Representatives Gephardt an
Stockman have proposed legislatio
to create incentive mechanisms f
subscribers, Medicare, and Medica
patients to buy the most cost-efficie
"qualified" plan with return of sa
ings tax-free to the subscriber. The
also then propose deregulation b
eliminating legislated health pla
ning and PSROs!

Cost-effectiveness deterrent

There are more. But, withou
question, we can stimulate consu
ers to accept health insurance pla
which promote cost-consciousnes
provide good care and cost-saving
and meet all objectives of the profe
sion for preservation of fee-for-ser
ice private practice.

The system CAN be changed.

MICHIGAN MEDICINE

February 1981 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 80, No. 5

Are we preparing too many physicians?

OF PHIL
MAR 4 - 1981

Here is Maternal Health Conference program and registration form

Location: Hyatt Regency Dearborn

Wednesday Morning, March 25

8:45 a.m. "Management of Premature Labor: Tocolysis and Fetal Affects" — Jeffrey Lipshitz, MB, ChB, associate professor, Division of Maternal/Fetal Medicine, Department of Obstetrics and Gynecology, University of Tennessee, Memphis

9:30 a.m. "Diagnosis and Management of Intrauterine Growth Retardation: The Mother" — James Crane, MD, assistant professor, Head of Genetics Unit, Barnes Hospital, St. Louis, MO

10:45 a.m. "Pediatric Management of the Intrauterine Growth-Retarded Infant" — Joseph B. Warshaw, MD, professor of pediatrics, obstetrics and gynecology, Yale University School of Medicine, New Haven, CT

11:30 a.m. Panel Discussion

Wednesday Afternoon, March 25

2:00 p.m. "The Critical First 10 Minutes of Life" — Gerard W. Ostheimer, MD, assistant professor of anaesthesia, Harvard Medical School, associate director of obstetrical anaesthesia, Brigham and Women's Hospital, Boston

2:40 p.m. "Ethical and Legal Issues in Resuscitation of the Newborn" — Norman Fost, MD, MPH, assistant professor of pediatrics, director of programs in medical ethics, director of residency program, University of Wisconsin Medical School, Madison

4:10 p.m. "Organization of the Resuscitation Team" — M. Jeffrey Maisels, MB, BCh, professor of pediatrics and obstetrics and gynecology, Chief, Division of Newborn Medicine, The Milton S. Hershey Medical Center, Pennsylvania State University, Hershey, PA

4:55 p.m. Panel/Questions and Answers

Thursday Morning, March 26

8:45 a.m. "Professional Well-Being: Resuscitation the Health Professional Experiencing Burnout" — Dan J. Pesut, RN, MSN, assistant professor, Psychiatric-Men Health Nursing, University of Michigan School of Nu ing, Ann Arbor

10:00 a.m. "Neonatal Neurologic Assessment and Pr jected Outcome" — Gary Goldstein, MD, University Ho pital, Ann Arbor

10:45 a.m. "What Happened to Our Baby and Wha Happening to Us?" — M. Neil Macintyre, PhD, profess Departments of Anatomy, Medicine, and Pediatriacs, Ca Western Reserve University School of Medicine, Clev land

11:30 a.m. Panel/Questions & Answers

Thursday Afternoon, March 26

1:30 a.m. "Discharge from the Neonatal ICU"
PANEL: Marianne Glassanos, RN, clinical nurse sp cialist, Holden Neonatal Nursery, University of Michig Hospital, Ann Arbor
Steve Donn, MD, University of Michigan Medical Cent Ann Arbor
Lillie Leverett, RN, Visiting Nurses Association of D troit, Detroit
Samuel J. Meisels, EdD, program director for special ed cation, Institute for the Study of Mental Retardation a Related Disabilities, University of Michigan, Ann Arbo

3:15 p.m. "The Next Twenty Years: A Review and Challenge" — J. Robert Willson, MD, professor, Depa ment of Obstetrics and Gynecology; Bates Professor Diseases of Women and Children, University of Michig Medical School, Ann Arbor

---

The program is approved for 11 hours of CME Category I credit, and accepted for 11 prescribed hours by The American Academy of Family Physicians.

Advance Registration

Complete and mail to the Michigan Conference on Maternal and Perinatal Health, Box 950, East Lansing, MI 48823

Name

Address

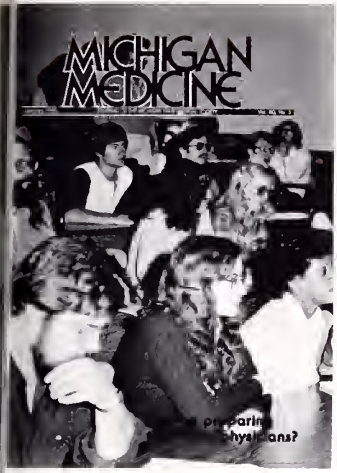
City Zip

Please check one:

Physician	RN	LPN	Student	Other
☐	☐	☐	☐	☐

Registration Fee:		Physician	Nurse	Other	Student/House Officer
Please Check	Wednesday Sessions	☐ $20	☐ $12	☐ $12	☐ No Charge
	Thursday Sessions	☐ $20	☐ $12	☐ $12	☐ No Charge
	Total	$	$	$	$ (none)

Make checks payable to Michigan State Medical Society



Students in a Michigan State University College of Human Medicine class help us illustrate our special report this month: a discussion of the controversial Graduate Medical Education National Advisory Committee Report, with its predictions of physician surpluses ahead. The special report begins on page 48. Photo by Mert Scholten, MSMS staff.

MICHIGAN MEDICINE
February 1981, Volume 80, Number 5

Special report

A new federal report predicts a surplus of 70,000 physicians in the United States by 1990. MSMS and other major health care professional groups are studying the report carefully. Some initial reactions, a summary of the Graduate Medical Education National Advisory Committee recommendations, the "inside story" on the report by three Michigan physicians who served on the committee, and statistical information on numbers of Michigan physicians are included in this special report; Charles C. Vincent, MD, Charles R. Downs, Yvan J. Silva, MD, Herbert A. Auer, and John G. Ditzhazy.

Features

44 New MSMS Impaired Physician Program launched; S.C. Mason, MD

60 List of specialty society presidents and secretaries

62 Legislative profile: Sen. Mitch Irwin; Willah Weddon

67 How to be a better expert witness; Kim White

Departments

45 Letters

72 News

74 Medical newsfronts

80 Category I courses

85 Meetings

86 Classified ads

87 Deaths

88 President's page; John R. Ylvisaker, MD

Thank to our Advertisers

Advance Medical Research Center 70
Brown Pharmaceutical 79
Burroughs Wellcome 63
Campbell Labs 68
Dempsey Data Service 80
I.C. System 81
Intrav 59
Eli Lilly 69
Marion Labs 55
Medical Protective 82
Mercywood Hospital 70
Michigan Physicians Mutual Liability Company 61
Mt. Carmel Mercy Hospital 47
Pennwalt Pharmaceutical 76, 77, 78
Physicians Insurance Company of Michigan 71
Purepac 73
Roche .... 46, 47, 57, 64, 65, 83, IBC, BC
Stat Medical Books 62
Stratton Cheeseman 75
U.S. Air Force 85
U.S. Army 72
Upjohn 84

New MSMS Impaired Physician effort drawing all MDs into helping network

By S.C. Mason, MD, Ann Arbor

An ambitious project was officially inaugurated Nov. 18 at the MSMS Annual Scientific Meeting. The project addresses one of the most urgent issues facing medicine as a professional discipline — the impaired physician in our midst.

This issue has been handled largely by neglect in the past. The MSMS Committee to Assist the Impaired Physician has tried valiantly to do something about it.

In the course of their efforts, however, it has become evident that the problem is much too big for a central committee to deal with effectively. As a result, a plan to decentralize the operation was conceived and put together by the committee.

This plan is called the "Michigan Model for a Physician Health and Well-Being System" and its essential feature is the formation of health and well-being committees by each component medical society, where they will be closely tuned to problems as they arise, and will be able to offer help promptly to a troubled colleague.

The objective is to draw the entire medical profession into a working network to assist those among us who are faltering due to emotional or physical illness or substance abuse. Physicians' spouses will be an important component of this network, as will the nursing profession, hospital administrators, and other allied health professionals.

The old MSMS Committee to Assist Impaired Physicians has been inactivated and a totally new entity has evolved. This will be known as the Impaired Physician Program. The organizational structure at the MSMS level will consist of five subcommittees, each of which will deal with one particular aspect of the problem.

1) "Research and Development" will keep our program in touch with similar developments nationally and working out more refined approaches to the problem.

2) "Finance" will administer the $50,000 fund MSMS has set aside as a reserve for grants and loans to financially distressed and/or impaired physicians.

3) "Promotions" will bring the Michigan Model Plan to each component medical society and show it how to set up a health and well-being committee and how to function effectively.

4) "Training" will educate members of the local committees in the techniques of intervention, by holding workshops and by developing audio-visual aids that will be available for local committees.

5) "Intervention" will have a supervisory role over all the intervention activities of the local committees and also will serve as back-up when insoluble problems are faced by the local committee. It also will be available in instances when no local committee has been established.

The chairman of each of these subcommittees will join with MSMS President John R. Ylvisaker, MD, chairman of the Impaired Physicians Program, in a steering committee which will coordinate the whole program.

Materials now are available to help the local committees function and have been compiled in a handbook. It is planned that each component medical society will receive one of these handbooks so that this information will be readily available.

The next crucial step will be to gain the acceptance of this concept by every member of our profession and to win their willing participation. The plan will stand on its own merits — it will sell itself by its inherent logic and clarity. But we do need to capture the attention of doctors, get them to look at this problem and at our professional solution.

Doctor Mason is a psychiatrist and member of the new MSMS Impaired Physician Program.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
James H. Tisdel, MD, Port Huron,
Chairman
Busharat Ahmad, MD, Marquette
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon

Editor
Judith Marr

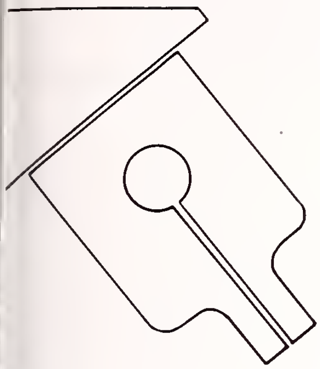
Michigan Medicine, the official journa the Michigan State Society, is dedica to provide useful information for Mic- gan physicians about actions of the Mi igan State Medical Society and contem rary issues, with special emphasis socio-economics, legislation and ne about medicine in Michigan.

The Michigan State Medical Soci Committee on Publications is the edito board of *Michigan Medicine* and advi the editors in the conduct and policy the magazine, subject to the policies the MSMS Council.

Neither the editors nor the state medi society will accept responsibility statements made or opinions expressed any contributor in any article or feat published in the pages of the journal. T views expressed are those of the wri and not necessarily official positions the society. Products and services adv- tised in *Michigan Medicine* are neit endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-22 is the official journal of the Michig State Medical Society, published un the direction of the Publications Comm- tee. Published three times a month, 36 sues by the Michigan State Medical So- ety as its official journal. Second cl postage paid at East Lansing, Mich. and additional mailing offices. Yearly s scription rate, $20.00; single copi $1.50. Additional postage: Canada, $1 year; Pan-American Union, $2.50 year; Foreign, $2.50 per year. Printed USA. All communications relative to a cles, news, exchanges, advertising, shou be addressed to Judith Marr, Michig State Medical Society, 120 West Sagin Street, East Lansing, Michigan 488 Phone Area Code 517, 337-1351. ©19 Michigan State Medical Society.

LETTERS



Dalkon Shields

We are pleased to note that you have eproduced our "Dear Doctor" letter of September 25, 1980 in the Letters section of your very fine Journal.

This will obviously help us to efect even more widespread dissemination of our recent recommendation hat all remaining Dalkon Shields be emoved from even asymptomatic users.

We sincerely appreciate your inerest in publishing the letter, and he complimentary copy which you were kind enough to send us.

Fletcher B. Owen, Jr., MD, PhD
Director of Medical Services
A.H. Robins Company
Richmond, VA

Medicaid-Medicare

Your November President's Page causes me to point out one item that would save money for the Medicaid-Medicare programs.

It has been my policy to try and give enough medications by script to last the patient for a month or two months. The druggist will, for example, give only 30 tablets of such items as Empirin or Tylenol c codeine at a time, even though the script was written for 60 tablets. This then requires the patient return for the other 30 tablets. This happens with other drugs such as Prednisolone and blood pressure medications. Such a policy puts a burden on the patient and costs extra for a refill script.

Frederick E. Ludwig, MD
Port Huron

Anti-fluoridationists and MSMS

During the past few years, a few anti-fluoridationists have bombarded state legislators and the governor's office in an effort to remove fluoride from the Lansing water system. The Governor wisely appointed a commission to study the problem, and after months of work published a report recommending that fluoridation be continued as is.

This report didn't discourage the "anti's," however, and they proceeded to present the issue on the ballot for a public referendum.

The fact that the President, the surgeon general, the AMA, the American Academy of Pediatrics, the National Cancer Institute, the allergy society, and many other reliable establishment institutions approve water fluoridation, does not discourage the opposition to fluoride. The following facts also do not impress them or discourage them in their negative effort.

Tooth decay is the number one disease of mankind and the dental bill last year for that half of the population that went to the dentist was $10 billion. Forty-four million Americans wear at least one denture. All natural water contains some fluoride but the problem is that it is either too little or too much. Fluoride ingested during the formative period of tooth development will remain in the tooth and protect it for the life of the tooth. Tooth decay and tooth loss will be reduced by approximately 65-70 percent if fluoride is taken during the critical time of tooth development and will be of some help even as a topical agent for the permanent teeth throughout life.

It would have been a real blow to the public health measure of fluoridation if, in the home of the Michigan Department of Public Health, the water fluoride program would have been destroyed.

The Public Information Committee of MSMS recognized the danger and destructiveness of removing fluoride from the water in Lansing and voted unanimously to take action to inform the community of its position.

Mert Scholten of the MSMS staff sent reliable information to the school systems, Howard C. Comstock MD, garnered the cooperation of the Lansing pediatricians to display and disseminate a fact sheet to their patients, and the members of the MSU medical faculty made their position known publicly.

The Michigan Dental Association did a magnificent job. Dental hygienists went from door to door with information, and members of the state dental group made their position clear through all of the media. The American Dental Association financed part of the project with a $10,000 grant.

When the final count was tabulated, the anti-fluoridationists were beaten by a three-to-one vote.

The thing that is so gratifying to me is that we took action simply because it was the right thing to do. Too often we only react when our own ox is gored.

I don't think our professional establishment fully recognizes the strength of its own political clout. There are many scientific areas where witchcraft is on the rise, in addition to the fluoridation issue.

It most certainly is our responsibility to gather scientific information and make it known to the general public.

Frederick J. Margolis, MD
Member, Public Committee, MSMS
Kalamazoo

Youthful eye care

We have received several requests for our statement on Infant and Children's Eye Care from doctors in Michigan who mentioned that they had read about the statement in *Michigan Medicine*.

We are appreciative of your efforts to help disseminate this information to the medical community.

Thank you again for your help.

Ricki Sara Bennett
Public Education Assistant
American Academy of
  Ophthalmology
San Francisco

more on page 58

half-life

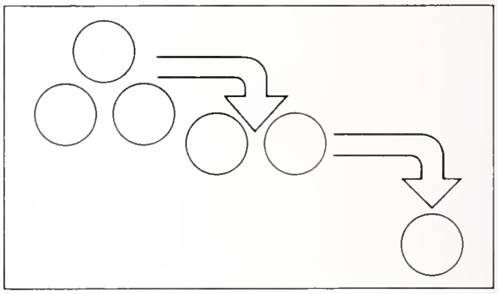
Just one built-in advantage

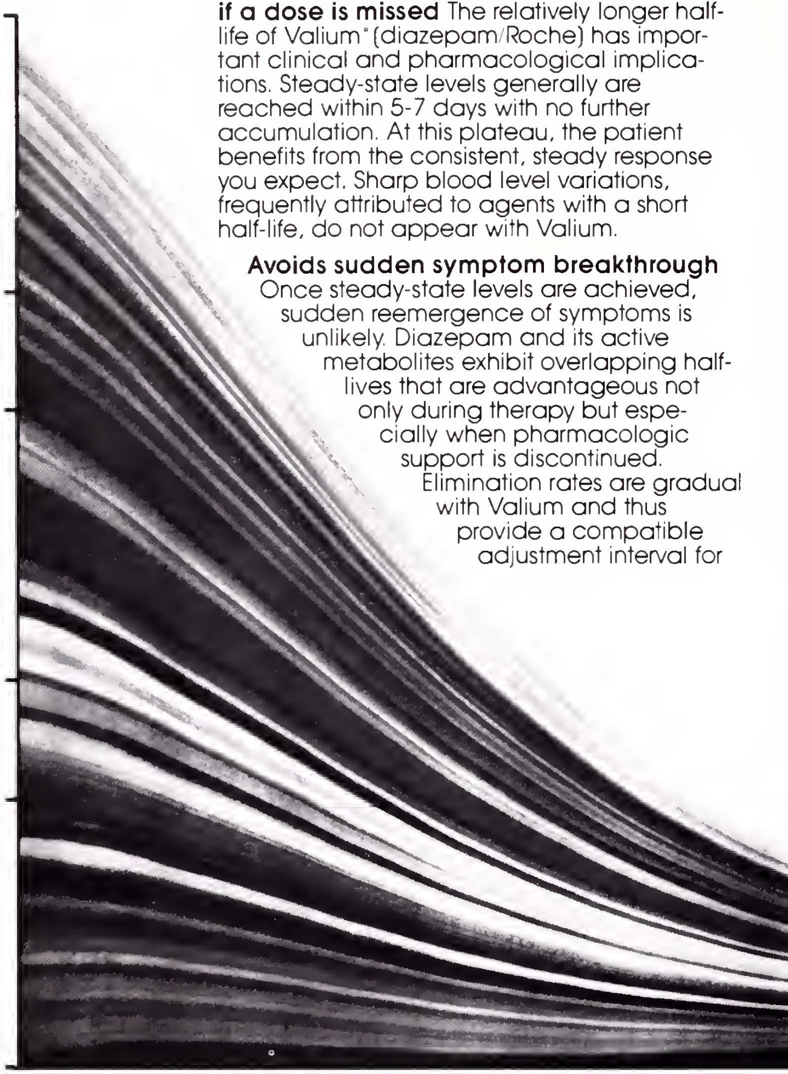
Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978





in the management of symptoms of anxiety

Valium® Ⓘⓥ

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

effective therapy through efficient pharmacodynamics

Before prescribing, please see summary of product information on next page

ROCHE®

Valium® ⓘⓥ
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient
Contraindicated: Known hypersensitivity to the drug Children under 6 months of age Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy, gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates MAO inhibitors and other antidepressants may potentiate its action Usual precautions indicated in patients severely depressed or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria jaundice, skin rash, ataxia, constipation, headache incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy

ROCHE®
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

coming May 1981 . . .

the international symposium on normoglycemia for the diabetic Detroit, Michigan

An outstanding international faculty will convene in Detroit, Michigan, on May 6 and 7, 1981, to address the following subjects:

- pancreatic organ transplant
- islet cell transplant
- mechanical insulin delivery systems

The symposium will focus on current experience, problems, possible solutions and projections for the future relating to normoglycemia for the diabetic patient.

Abstracts relating to the symposium are invited and topics will be accepted until February 15, 1981.

Symposium Chairmen
Sander P. Klein, M.D.
Endocrinology

Luis H. Toledo-Pereyra M.D., Ph.D.
Transplantation

Sponsored by:
Eli Lilly and Company and
Mount Carmel Mercy Hospital,
Detroit, Michigan

registration information

Tuition: $100 (US currency); CME credit available. Special rates available for students, nurses and resident physicians.

☐ Yes, I'm interested in attending. Please send me more information.

☐ I would like to submit the following abstract topic for consideration:

Topic ______________________________
____
Name______________________________
Title______________________________
Address ______________________________

Mail to: Mount Carmel Mercy Hospital
c/o Transplantation Department
6071 West Outer Drive
Detroit, Michigan USA 48235

SPECIAL REPORT

Michigan physicians and the GMENAC Report

By Charles C. Vincent, MD, Detroit

A cautious and very careful scrutiny of the recently-released Graduate Medical Education National Advisory Committee (GMENAC) report should be performed by all members of the Michigan State Medical Society interested in the future of health care delivery in our State.

After a four-year review (and $4,000,000) the Committee (GMENAC) has presented its final report to the Secretary of Health and Human Services. The major conclusion of this report is the projected 70,000 excess physicians in the United States by 1990, with overwhelming surpluses in 18 medical specialties.

While there are 107 recommendations made by the Committee, the ones which specifically pertain to those of us who render health care to citizens within our state are:

1) Reduction of 10 percent (from the 1978 level) of first-year students in medical schools;

2) Severe restriction on the entry into practice of physicians trained in non-US medical schools;

3) Incentives to encourage residents to enter into shortage specialties;

4) Reduction in residency positions in oversupplied specialties;

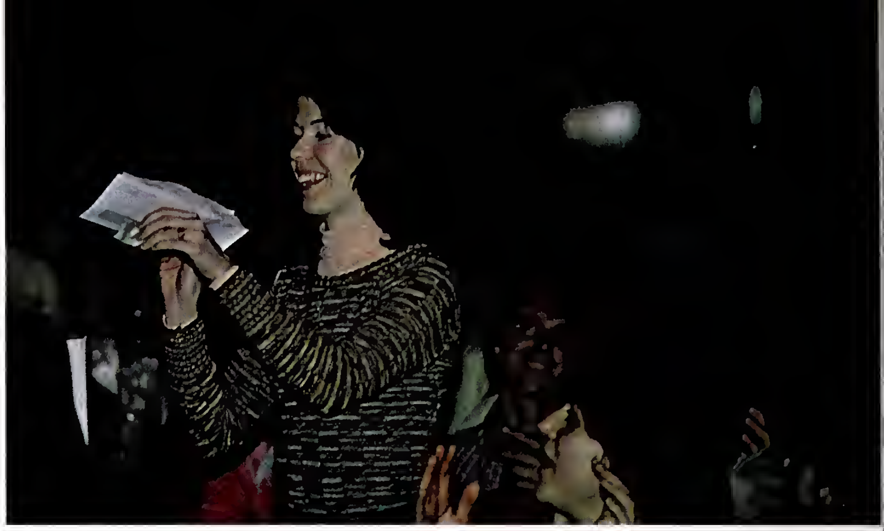
5) Holding the number of physician assistants, nurse practitioners and nurse midwives in training to current levels;

6) Discontinuation of the fifth pathway program;

7) Elimination of federal educa-

Doctor Vincent is associate dean of student affairs at Wayne State University School of Medicine, and is chairman of the MSMS Medical Education Policy Committee.

continued on page 52



University of Michigan Medical School graduate celebrates a 'match day' residency assignment.

What is GMENAC?

What is all this talk about? What is this GMENAC (pronounced jem-en-ack Report?

"After three years of comprehensive health manpower analysis, the Graduate Medical Education National Advisory Committee (GMENAC), collaborating in an intense relationship between federal government and the health profession, working with panels of experts, assisted by technical staff from the Department of Health and Human Services, and debating in public forum, has identified seven major health manpower problems with the words TOO MANY, IMBALANCES, UNEVEN, COMPLEX, UNKNOWN, and UNCERTAIN."

This statement is from the GMENAC Summary Report, a 42-page condensation of a giant full report sent by the national advisory committee in September, 1980 to the secretary of the Department of Health and Human Services.

"There will be TOO MANY physicians in 1990," elaborates the GMENAC Summary Report. "There will be substantial IMBALANCES in some specialties. There will continue to be a marked UNEVENNESS in the geographic distribution of physicians. The country may be training TOO MANY nonphysician providers for 1990. The factors influencing specialty choice are COMPLEX. The actual cost of graduate medical education is UNKNOWN. Economic motivation in specialty and geographic choice is UNCERTAIN."

The GMENAC report, containing 107 recommendations addressing these predictions, specifically forecasts a surplus of 70,000 physicians by 1990. It calls for a reduction in medical school enrollment and for incentives to expand residencies in primary care specialties.

The advisory committee was chartered in April, 1976 and again in March, 1980, to advise the (then HEW) secretary "on the number of physicians required in each specialty to bring supply and requirements into balance, methods to improve the geographic distribution of physicians, and mechanisms to finance graduate medical education."

GMENAC, chaired by Alvin R. Tarlow, MD, of the University of Chicago, is composed of 21 members, including 13 physicians. Three of the physician members are from Michigan — Robert B. Carbeck, MD, and Delores Garcia, MD, of Ann Arbor, and Myron S. Magen, DO, of East Lansing. Their observations of the GMENAC process and the committee's recommendations appear in an accompanying article.

Health care delivery for several generations could be affected by the recommendations of the National Advisory Committee, said AMA Executive Vice President James H. Sammons, MD, as the committee's massive report was forwarded to the secretary of Health and Human Services.

"Because of the methodology used by GMENAC, it is necessary to view the recommendations with caution before they are applied to the American health care system," Doctor Sammons said. "Our concern is that this report has the potential to set the American system on a rigidly defined course with little flexibility of goals or the means of attaining them. We must keep in mind that while the GMENAC findings may provide an interesting assessment of manpower projections and supply today, history has shown that long-term medical manpower projections are extremely difficult to make, given changing economic trends, technological innovations, a mobile population, and a rising demand for services."

Those recommendations the MSMS Committee on Medical Education Policy is most concerned with (see Doctor Charles Vincent's accompanying article) are listed in full as follows:

GMENAC Recommendations

1) Allopathic and osteopathic medical schools should reduce entering class size in the aggregate by a minimum of 10 percent by 1984 relative to the 1978-79 enrollment, or 17 percent relative to the 1980-81 entering class.

2) The number of graduates of foreign medical schools entering the US yearly, estimated to be 4,100 by 1983, should be severely restricted. If this cannot be accomplished, the undesirable alternative is to decrease further the number of entrants to US medical schools.

3) The need to train nonphysician health care providers at current levels should be studied in the perspective of the projected oversupply of physicians.

4) To correct shortages or surpluses in a manner not disruptive to the GME system, no specialty or subspecialty should be expected to increase or decrease the number of first year trainees in residency or fellowship training programs more than 20 percent by 1986 compared to the 1979 figure.

5) In view of the aggregate surplus of physicians projected for 1990, medical school graduates in the 1980s should be strongly encouraged to enter those specialties where a shortage of physicians is expected or to enter training and practice in general pediatrics, general internal medicine, and family practice.

6) Extensive research on the requirements for NPs, PAs, nurse-midwives, and other nonphysician providers should be undertaken as soon as possible. Special attention must be given to the effect of a physician excess on their utilization and to the benefits these providers bring to health care delivery. These studies should consider the full range of complementary and substitute services.

7) Until tne studies in Recommendation 6 have been completed, the number of PAs, NPs, and NMWs in training for child medical care, adult medical care, and obstetrical/gynecological care should remain stable at their present numbers. Delegation levels recommended by GMENAC for 1990 are: in obstetrics/gynecology 197,000 of the normal uncomplicated deliveries (5 percent of all deliveries), 7.1 million maternity related visits (20 percent of the obstetrical caseload), and 7.5 million gynecological visits (18 percent of the gynecological caseload); in child care not more than 46 million ambulatory visits (16 percent of the child ambulatory caseload); and in adult medical care not more than 128 million ambulatory visits (12 percent of the adult medical ambulatory caseload).

11) Medicare, Medicaid, and other insurance programs should recognize and provide reimbursement for the services by NPs, PAs, and nurse-midwives in those states where they are legally entitled to provide these services. Services of these providers should be identified as such to third party payors and reimbursement should be made to the employing institution or physician.

12) NPs, PAs, and nurse-midwives should be eligible for all federal incentive programs directed to improving the geographic accessibility of services, including the National Health Service Corps Scholarship Program.

17) GMENAC recommends that health manpower shortage areas be defined by a minimum service specific physician to population ratio and a maximum travel time to service for child care, adult medical care, obstetrical services, general surgical services, and emergency medical services.

19) Medical students should be encouraged to select a location for practice in underserved rural and urban areas by several approaches: (1) having an interest, (2) governmental loan and scholarship programs should be catalogued and evaluated to determine their effectiveness in improving geographic distribution, (3) loan forgiveness programs modeled after those which have been successful should be used, and (4) the National Health Service Corps and its scholarship program should be supported.

20) The medical profession in making decisions as to residency training programs should consider the aggregate number of programs, their size, and the geographic distribution of their graduates, in addition to the quality of the program, in light of national and regional needs.

21) Family practice residency training programs should be supported since these programs tend to train providers who are more likely to choose to practice in underserved areas. A similar rationale underlies support needed for resident experiences in underserved areas and for certain nonphysician provider training programs.

24) Medical education in the medical schools and in the early phase of graduate medical education in the teaching hospitals should provide a broad-based clinical experience with emphasis on the generalist clinical fields. A portion of graduate medical training should occur in other tertiary care medical centers.

26) Greater diversity among the medical students should be accomplished by promoting more flexibility in the requirements for admission; by broadening the characteristics of the applicant pool with respect to socio-economic status, age, sex, and race; by providing loans and scholarships to help achieve the goals; and by emphasizing, as role models, women and under-represented minority faculty members.

27) Information about physician manpower needs in the various specialties and in different geographic settings should be disseminated broadly to medical schools; administrators; faculty; and medical students, residents, fellows, and spouses.

28) Capitation payments to medical schools for the sole purpose of increasing class size or for influencing specialty choice should be discontinued in view of the impending surplus of physicians.

29) Special purpose grants to medical schools and other teaching institutions for primary care training in family medicine, general internal medicine, and general pediatrics should be continued in order to continue and increase the emphasis on primary care services and ambulatory care.

34) Public and private reimbursement policies should be adjusted to: emphasize ambulatory care services and training; encourage practice in underserved areas; explore the concept of shared risk among physicians; and pay professional fees to teaching physicians when their services have been identifiably discrete and necessary.

37) Special project grants for states on a cost sharing basis should be considered to influence the geographic distribution of physicians within the states. The development of incentives for practice in underserved areas is one program to be considered.

40) In addition to the continuous monitoring, the supply projections, requirements estimates, and recommendations of GMENAC in their entirety must be reevaluated and modified at least every five years to take account of changes in data, assumptions, and priorities occurring over time.

SPECIAL REPORT/*continued*

Michigan MDs who served on GMENAC call it a rewarding experience

By Charles R. Downs, special to Michigan Medicine

Doctor Carbeck

Doctor Magen

In the sense that, "politics is the art of the possible," the recent report of the Graduate Medical Education National Advisory Committee, (GMENAC) is a political committee and its report a political report.

The major significance of the controversial study, say three committee members from Michigan, is that it was made at all.

It is enough, they contend, that physicians and nonphysicians representing many divergent viewpoints and interests were able to reach consensus on a wealth of data and conclusions bearing on the future of graduate medical education.

Robert B. Carbeck, MD, executive vice president of Catherine McAuley Health Center in Ann Arbor; Delores Garcia, MD, chief resident in pediatrics at the University of Michigan Health Center, and Myron S. Magen, DO, dean of the College of Osteopathic Medicine at Michigan State University, say they are substantially in agreement with all the major findings of GMENAC.

Each acknowledges that he or she might have written the report differently if he or she had been in charge. Doctor Magen, for example, says he thinks it was not consistent to differentiate between MDs and DOs with respect to family practice since no such differentiation was made in respect to other specialties. But none of the three thought it necessary to write a dissenting viewpoint.

Government, private sector

"For the first time," claims Doctor Carbeck, "the government and the private sector have worked on a problem together and have come up with answers they can agree on.

"Everything in the report is supportable by research, and represents a consensus. If something had come up that one person just could not go along with, the chances are that others would have felt the same way and that part would have been changed or discarded."

Doctor Magen concurs: "The report proposes a model for analyzing health manpower. It also addresses the issue of productivity and proposes ways of evaluating productivity which, while they may be imperfect, do offer some means of resolving the issues.

"Whether or not the report is correct in all aspects is not important. If you are going to make a determination about graduate medical education, you have to start somewhere. And I think this report is a good start."

Medical data scarce

Doctor Magen says he was amazed at the paucity of the medical manpower data that was available.

"The first job of the committee," he says, "was to determine the adequacy of the data. We knew that the worse the input, the worse the output would be.

"If nothing else, a good start has been made in centralizing health manpower data."

Doctor Carbeck says that some of the findings which have since stimulated the most controversy were not controversial when they were discussed by the committee. For example, the finding that there will be an oversupply of 70,000 physicians in 1990 was "accepted as supportable and realistic," says Doctor Carbeck.

Doctors Carbeck, Garcia and Magen acknowledge that it can legitimately be argued that a surplus of physicians may be a good thing, although the report assumes a surplus would be bad.

"But," notes Doctor Garcia, "our charge was not to specify whether a surplus is good or bad. Our charge was to see how many physicians and other health professionals are out there."

Doctor Carbeck concurs: "The issue was not addressed, probably because of the nature of the committee members. It was basically a given that a surplus is bad because medical education is subsidized by the federal government."

Ethics of surplus

The ethics of a surplus were not the only issues that did not receive much attention. One that is of particular concern to Doctor Garcia is the possible impact of the report on enrollment of minorities.

"I don't think the report will have an impact on women because they are so well-accepted in medicine now. But there may be a problem for minorities. One of my regrets is that the issue was not discussed more."

Doctor Garcia also points out that increased numbers of physicians are already having an impact on physician mobility.

"New doctors are already finding it hard to get jobs, particularly those in certain specialties and those who want to go to the more popular states," she points out.

"It used to be that if you had a degree, you could go anywhere. The trend now is to go in with someone with an established practice."

Doctor Garcia does not expect her career to be personally affected by a surplus. She plans to do graduate study in public health and eventually take a position in that area, which is not expected to have a surplus.

A challenging experience

The three physicians found their roles on the committee challenging and demanding. Two-day meetings were held every other month and in between there were subcommittee meetings and working sessions. Doctors Carbeck and Magen served on the Plans and Methods Subcommittee, which functioned as an executive group.

Doctor Magen also served on the Finance Subcommittee and was chairperson of the Subcommittee on Educational Environment, which looked at the relationship between specialties chosen and the education milieus provided.

Doctor Carbeck also served as chairperson of the Subcommittee on Non-physician Health Care Providers and on the Geographic Distribution Subcommittee. This latter group, he notes, came up with new definitions for underserved areas. These definitions are expressed in terms of the time needed by residents to avail themselves of certain basic medical services. For example, 30 minutes to reach a family doctor was considered adequate, as was 45 minutes to reach an obstetrician and 90 minutes to reach a surgeon.

Doctor Garcia served on the Finance Subcommittee and the Subcommittee on Educational Environment.

The 22 members of GMENAC worked very well together, says Doctors Carbeck, Garcia and Magen, especially when it is considered that each represented a different background and perspective. There were 13 physicians (including one each from the Navy, Veterans Administration and Department of Health and Human Services — initially Health, Education and Welfare), two nurses, an economist, a hospital administrator, two lawyers, and three federal officials.

In spite of the difficulty of the assignment, the Michigan trio found the experience rewarding. And, if GMENAC is extended by the Congress or the new administration, Doctors Carbeck, Garcia and Magen are willing to continue serving.

Figure 1

Ratio % of GMENAC projected supply to estimated requirements — 1990

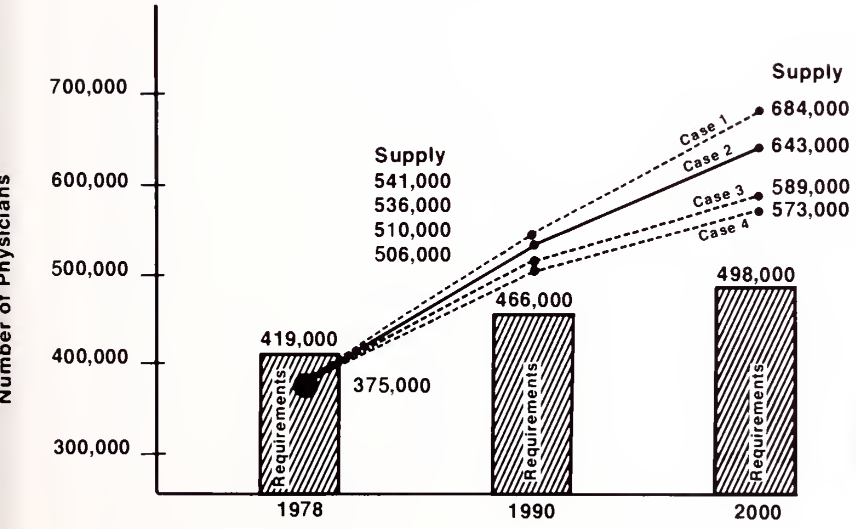
	Ratio %	Requirements	Surplus (shortage)
Child Psychiatry	45%	9,000	(4,900)
Emergency Medicine	70%	13,500	(4,250)
Preventive Medicine	75%	7,300	(1,750)
General Psychiatry	80%	38,500	(8,000)
Hematology/Oncology-Internal Medicine	90%	9,000	(700)
Dermatology	105%	6,950	400
Gastroenterology-Internal Medicine	105%	6,500	400
Osteopathic General Practice	105%	22,000	1,150
Family Practice	105%	61,300	3,100
General Internal Medicine	105%	70,250	3,550
Otolaryngology	105%	8,000	500
General Pediatrics and Subspecialties	115%	36,400	4,950
Urology	120%	7,700	1,650
Orthopedic Surgery	135%	15,100	5,000
Ophthalmology	140%	11,600	4,700
Thoracic Surgery	140%	2,050	850
Infectious Diseases-Internal Medicine	145%	2,250	1,000
Obstetrics/Gynecology	145%	24,000	10,450
Plastic Surgery	145%	2,700	1,200
Allergy/Immunology-Internal Medicine	150%	2,050	1,000
General Surgery	150%	23,500	11,800
Nephrology-Internal Medicine	175%	2,750	2,100
Rheumatology-Internal Medicine	175%	1,700	1,300
Cardiology-Internal Medicine	190%	7,750	7,150
Endocrinology-Internal Medicine	190%	2,050	1,800
Neurosurgery	190%	2,650	2,450
Pulmonary-Internal Medicine	195%	3,600	3,350
* Physical Medicine and Rehabilitation	75%	3,200	(800)
* Anesthesiology	95%	21,000	(1,500)
* Nuclear Medicine	N/A	4,000	N/A
* Pathology	125%	13,500	3,350
* Radiology	155%	18,000	9,800
* Neurology	160%	5,500	3,150

he requirements in these six specialties were estimated crudely after a review of the erature. They should be considered as very rough approximations, and tentative. he full GMENAC modeling methodology will be applied to them in 1980-1981.

upply numbers for Nuclear Medicine are not available.

FIGURE 2

Aggregate Physician Supply & Requirements Under GMENAC Assumption 1978, 1990, 2000



SPECIAL REPORT/*continued*

Michigan MDs current statistics:

Table 1
Number of medical doctors licensed by Michigan, 1978

Location	Total Number Licensed
All Locations	15,540
Out of State	3,772

Table 2
Number of osteopathic physicians licensed by Michigan, 1978

Location	Total Number Licensed
All Locations	2,858
Out of State	553

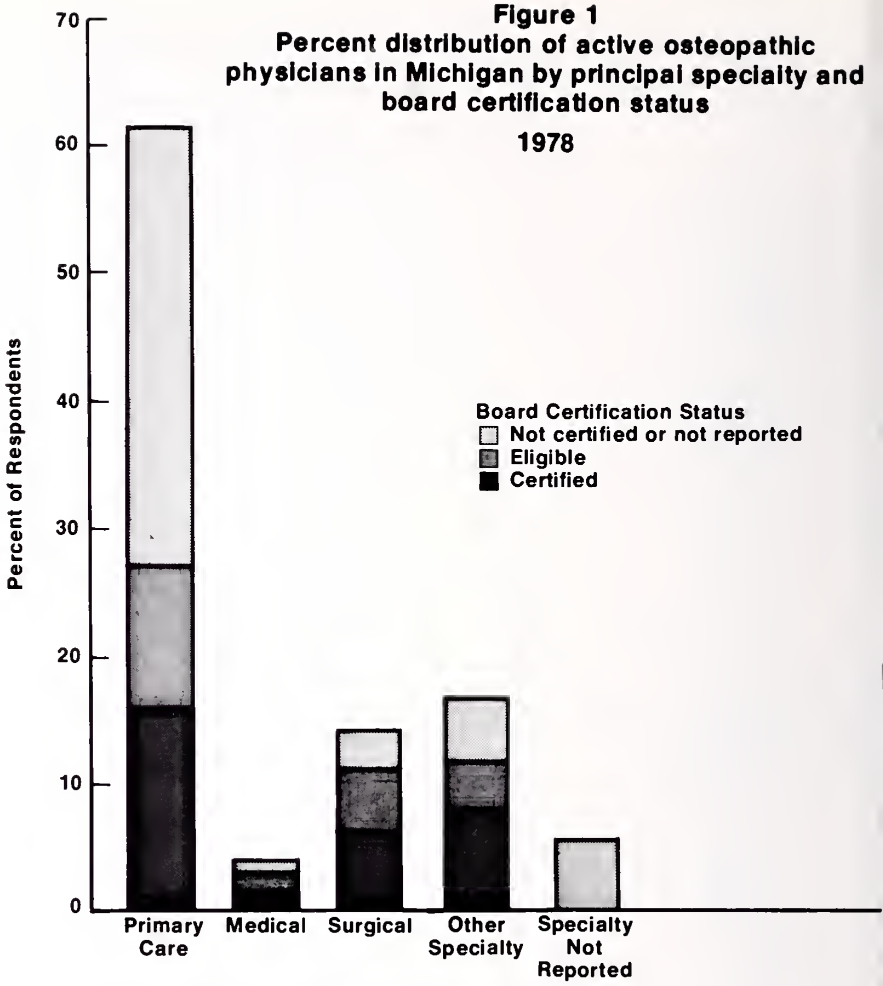


Figure 1
Percent distribution of active osteopathic physicians in Michigan by principal specialty and board certification status
1978

(Michigan Cooperative Health Information System Figures.)

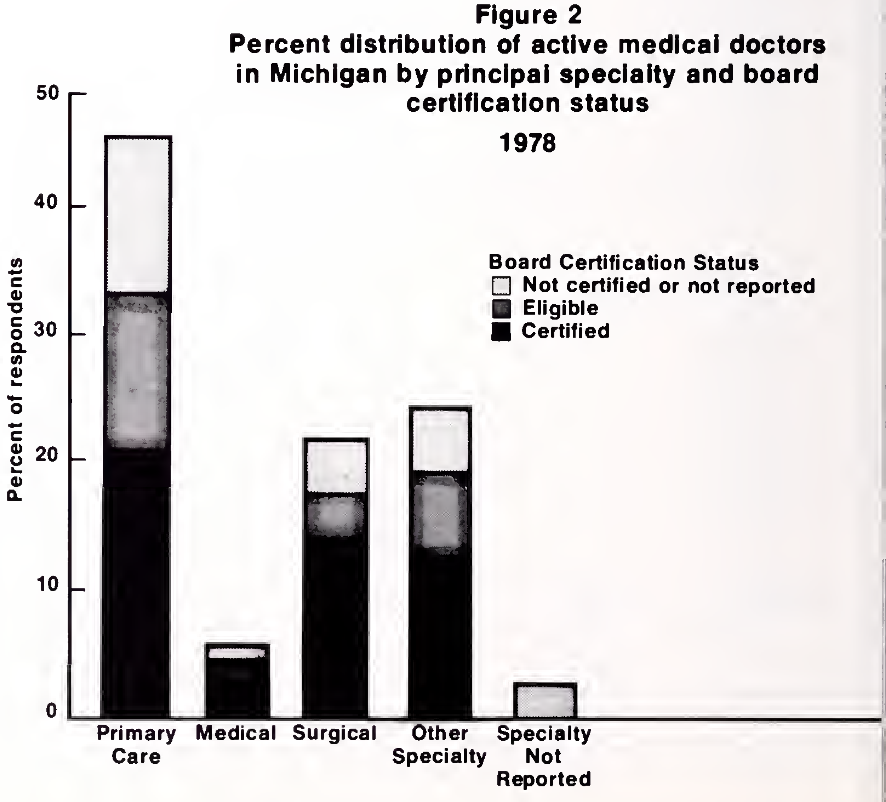


Figure 2
Percent distribution of active medical doctors in Michigan by principal specialty and board certification status
1978

DOCTOR VINCENT/*continued*

tion assistance to students attending foreign medical schools, and

8) Establishment of a successor to GMENAC as a statutorially creative body.

Although there has been considerable discussion regarding these recommendations, it would be valuable to our MSMS Medical Education Policy Committee to have your opinion regarding several of these recommendations.

That this report is voluminous and has the potential of significantly altering the practice of medicine as we now perceive it is quite obvious. Theoretical practices were instituted in reaching some of these conclusions and if proved incorrect, as has occurred in the past, could have a disastrous effect on an already crippled health care delivery system.

Because your state society will be making recommendations to the AMA, the Education Policy Committee would value your opinion and suggestions supporting or disagreeing with these recommendations.

Please send me your opinions in care of the MSMS Committee on Medical Education Policy at 120 W. Saginaw, East Lansing, MI 48823. All responses will be discussed by the Committee and incorporated into any conclusions or recommendations we make to our council.

Table 3
Estimated number and percent distribution of active medical doctors in Michigan by principal specialty, 1978

Principal Specialty	Estimated Number Active	Percent of Total Active
All Specialties	11,590	100.0
Primary Care Specialties	5,317	45.9
Family Practice	719	6.2
General Practice	932	8.0
Internal Medicine	1,958	16.9
Obstetrics and Gynecology	864	7.5
Pediatrics	844	7.3
Medical Specialties	595	5.1
Allergy	65	0.6
Cardiovascular Diseases	131	1.1
Dermatology	175	1.5
Diabetes	1	0.0
Endocrinology	17	0.2
Gastroenterology	45	0.4
Geriatrics	4	0.0
Hematology	26	0.2
Infectious Diseases	14	0.1
Neoplastic Diseases	39	0.3
Nephrology	15	0.1
Pediatrics, Allergy	5	0.1
Pediatrics, Cardiology	3	0.0
Pulmonary Diseases	31	0.3
Rheumatology	24	0.2
Surgical Specialties	2,551	22.0
Eye, Ear, Nose and Throat	532	4.6
Ophthalmology	372	3.2
Otology	12	0.1
Otorhinolaryngology	148	1.3
Surgery	2,019	17.4
Abdominal Surgery	3	0.0
Cardiovascular Surgery	29	0.3
Colon and Rectal Surgery	32	0.3
General Surgery	1,050	9.1
Gynecology	34	0.3
Hand Surgery	4	0.0
Head and Neck Surgery	2	0.0
Neurological Surgery	84	0.7
Orthopedic Surgery	362	3.1
Pediatric Surgery	14	0.1
Plastic Surgery	91	0.8
Thoracic Surgery	82	0.7
Traumatic Surgery	3	0.0
Urological Surgery	229	2.0
Other Specialties	2,831	24.4
Anesthesiology	412	3.6
Pathology	406	3.5
Clinical Pathology	22	0.2
Forensic Pathology	4	0.0
Pathology	380	3.3
Psychiatry	873	7.5
Child Psychiatry	64	0.6
Psychiatry	793	6.8
Psychoanalysis	16	0.1
Radiology	591	5.1
Diagnostic Radiology	99	0.9
Diagnostic Roentgenology	3	0.0
Radiology	458	4.0
Therapeutic Radiology	31	0.3
Other	549	4.7
Aerospace Medicine	4	0.0
Emergency Medicine	188	1.6
General Preventive Medicine	26	0.2
Neurology	110	0.9
Neurology, Child	2	0.0
Neuropathology	3	0.0
Nuclear Medicine	18	0.2
Occupational Medicine	102	0.9
Pharmacology, Clinical	9	0.1
Physical Med. and Rehab.	59	0.5
Public Health	25	0.2
Other Specialty	3	0.0

Table 5
Number of medical doctors in Michigan in graduate educational status by principal specialty and location of employment (coincides with HSA areas), 1978

Principal Specialty	Michigan	Southeast (Area 1)	Mid-South (Area 2)	Southwest (Area 3)	West (Area 4)	GLS (Area 5)	East Central (Area 6)	North Central (Area 7)	Upper Peninsula (Area 8)
All Specialties	1,575	1,289	49	30	115	43	34	9	6
Primary Care Specialties	796	640	30	15	58	27	24	—	2
Family Practice	93	35	10	3	15	11	19	—	—
General Practice	26	21	—	—	1	1	2	—	1
Internal Medicine	437	383	11	12	21	8	1	—	1
Obstetrics and Gynecology	115	94	5	—	13	2	1	—	—
Pediatrics	125	107	4	—	8	5	1	—	—
Medical Specialties	80	77	3	—	—	—	—	—	—
Surgical Specialties	393	318	4	10	40	8	8	1	4
Other Specialties	256	220	10	3	10	4	1	8	—
Specialty Not Reported	50	34	2	2	7	4	1	—	—

[1] This table is based on data from the 1,575 licensees who reported that they were residents or fellows. All but two of the 1,575 licensees reported that they were active in medicine.

Is the GMENAC Report important, valid?

The GMENAC Report, says Yvan J. Silva, MD, Detroit, must be considered in the context of other, recently-published materials on the same subject.

"So many new things have been happening since the report was initiated," explains the Harper Hospital surgeon who serves on the board and on the Policy and Planning Committee of the Educational Council for Foreign Medical Graduates.

Among those new developments, he says, is the movement of 10,000 to 12,000 American students to study medicine abroad.

"Even if we cut medical school class sizes following GMENAC recommendations to the letter," says Doctor Silva, "the number of American students coming back to the States will contribute a further 20 to 25 percent surplus if the GMENAC statements are correct."

In Doctor Silva's medical education circles, he says, the biggest issue of debate is how best to bring those American students abroad back into the American mainstream. His cohorts see a new cycle of issues involving foreign medical graduates, he says.

In addition, he observes, where FMGs in the past were basically apolitical and indeed, had no political clout in America due to their foreign origins, the American students studying abroad will have a great deal of political power and will have to be recognized when they return here.

Doctor Silva rates the GMENAC Report "extremely important." But he has reservations.

"It represents a concerted effort at gathering data," he comments. But he says the data are hard to interpret, the recommendations are not all valid and the study methodology is open to question.

"For instance," he says, "the very important issue of increasing public demand for medical services was not addressed. We have some data which show the demand made by the public for medical services increased in the 1970's by 20 percent over the previous decade.

"While GMENAC statistics on the supply of medical care may have been borne out by their data gathering," he says, "the other part (demand) of the equation has to be figured. And that is hard to figure."

Blue Pencil sketch

By Herbert A. Auer, East Lansing

Is there a surplus of physicians in Michigan today?

Are more doctors needed in Michigan now? Will they be in the next five or 10 years?

In regards to those questions, the Michigan Health Council Physician Placement Service receives phone calls every week from communities that need/want more doctors, from older physicians who want to have some younger physician take over their practice, from hospital medical staffs that report shortages in certain specialties, from state prisons and mental hospitals that have needs, etc.

The Health Council has no evidence of an over-supply of physicians in Michigan today.

There are 137 Michigan communities registered with the Placement Service along with 18 Rural Health Initiative clinics recruiting physicians. And, there are 50 to 70 areas in Michigan that have been identified as "medical shortage areas" in the Federal Register. The locations are all across the state.

The "Roster of Opportunities" for MDs and DOs in Michigan being distributed by MHC lists far more openings for primary care physicians — especially family physicians — than any other specialty. This is not a new phenomenon but has been the situation over the years.

While the MHC Board of Trustees has not studied the GMENAC report formally at any meeting, many trustees are quite knowledgeable. Their responses to the GMENAC recommendations vary to some degree depending upon medical specialty and geographic area.

May we point out several special situations that may not be readily apparent to leaders in the related fields of health care, education and government?

The number of MDs and DOs providing patient care in Michigan hit an all-time low before the end of World War II, in 1945. Many physicians were called into military service.

After WW II ended physicians returned to resume practice in Michigan and new physicians came to the state. Many of these physicians were 25-35 years old. Those physicians now are 60-70 years old. Some have retired and many more will retire in the next five to 10 years. The likelihood of physicians retiring earlier is greater now because of better retirement planning.

Judging from the activities of the MHC Physician Placement Service, the people in the rural and smaller Michigan communities are eager for more and better medical care. Levels of expectation are higher. Opportunities are good.

The unmet health care needs of inner-city residents are recognized generally. There have been statements by federal authorities that more of the medical students in the

continued on page 56

Mr. Auer is executive vice president of The Michigan Health Council.

"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

PAVABID® AND PAVABID® HP
(papaverine hydrochloride)
150-mg Capsules 300-mg Capsulets

Patient benefit products from

PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY MO 64137

6/80

National Health Service Corps Scholarship program will practice in inner-city areas rather than rural communities, as has been the practice. There are a reported 230 medical students today in the four Michigan medical schools who are Scholarship recipients.

The postgraduate training of scholarship recipients and their placement in underserved areas will change some of the physician recruitment practices and successes in Michigan, I believe.

Individuals and organizations studying the potential impact in Michigan re the GMENAC recommendations may find new, helpful information from the recently printed *Michigan Health Manpower Survey Technical Report.* The Michigan Health Council conducted a survey of health care professionals in Michigan in 1980 under a major grant from the W.K. Kellogg Foundation of Michigan and a smaller grant from the Michigan Department of Labor. Copies of the Technical Report may be obtained for $5 from the Michigan Health Council, 1407 S. Harrison Rd., Suite 340, East Lansing, 48823.

Med School Grads in Michigan since 1950

	Wayne	U of M	MSU CHM	MSU COM	Total
1950	58	(NA) —	—	—	58
51	62	(NA) —	—	—	62
52	62	128	—	—	190
53	59	137	—	—	196
54	65	155	—	—	220
55	67	173	—	—	240
56	63	189	—	—	252
57	65	186	—	—	251
58	72	169	—	—	241
59	66	186	—	—	252
1960	63	177	—	—	240
61	71	177	—	—	248
62	107	169	—	—	276
63	110	169	—	—	279
64	111	174	—	—	285
65	98	174	—	—	272
66	73	191	—	—	264
67	98	181	—	—	279
68	124	186	—	—	310
69	118	200	—	—	318
1970	132	189	—	—	321
71	144	201	—	—	345
72	141	188	31	—	360
73	121	204	34	42	401
74	169	216	55	30	470
75	207	230	75	68	580
76	239	224	87	71	621
77	251	227	90	76	644
78	252	251	107	89	699
79	255	256	102	98	711
1980	257	225	107	100	689

By John G. Ditzhazy, Lansing

It is the opinion of the Statewide House Officers Training System, Inc. (SHOTS) that the Graduate Medical Education National Advisory Committee (GMENAC) report is extremely important to those in the graduate medical education community.

The report highlights physician manpower issues, many of which will be debated nationally.

Secondly, the report provides information and data which will make the debate more meaningful and will stimulate other groups to produce better data and information.

The report is the product of a highly creditable committee composed of individuals from both the public and private sectors. This collaborative effort has produced a comprehensive report which is perhaps one of the best efforts to date to address health manpower issues.

The information and data used by the committee was, in general, the best available. It is important to note however, that these data contain imperfections. The intent of the committee was to maximize the use of available data and, hopefully, stimulate others to review and verify it and, if necessary, develop an improved data base. It is incumbent upon both the government and nongovernmental sectors to provide better data whenever possible.

The end results of this extensive review of both the available literature and data related to health manpower issues is a substantial number of recommendations — 107 in all. With so many recommendations it is difficult to generalize as to their "validity" as a whole. Certainly, there is insufficient space to adequately address each recommendation within this statement. Each of the 10 SHOTS member organizations are currently assessing the strengths and weaknesses of the recommendations in terms of their perceptions.

SHOTS, in fulfilling one of its major purposes, will be working to develop a consensus among these organizations and the graduate medical education community in general. Clearly, the process of accurately assessing the validity of the GMENAC recommendations will take time and reports to this effect will be forthcoming.

The impact of the GMENAC recommendations on the future of physician manpower in Michigan is difficult to determine. However, if the recommendations are adopted and implemented judiciously and selectively there may well be an improvement in the geographic and specialty distribution of physicians in Michigan.

As the purpose of SHOTS is "to better meet the physician requirements of the people of Michigan through modifications in graduate medical education," this outcome is viewed as desirable, and consistent with SHOTS policy.

Mr. Ditzhazy is administrative director of SHOTS.

Without the innovators, there could be no imitators

Librium® C (chlordiazepoxide HCl) Roche
Premarin (conjugated estrogens) Ayerst Laboratories
HydroDiuril (hydrochlorothiazide) Merck Sharp & Dohme
Lanoxin (digoxin) Burroughs Wellcome Co.
Lasix (furosemide) Hoechst-Roussel
Meticorten (prednisone) Schering Corporation
Anturane (sulfinpyrazone) Ciba-Geigy Corporation
Erythrocin (erythromycin) Abbott Laboratories

Research and development, the life blood of pharmacotherapeutic progress

The drugs that have contributed so much to modern medicine were the product of long years of expensive research. And tomorrow's drugs depend upon continuation of the research and development going on right now. The cost of that research is one of the things reflected in the price of a brand-name drug. The substitution of a cheaper "generic" drug for a brand-name product may save the patient some money at the prescription counter. However, it threatens the very foundations of modern pharmaceutical research.

The hidden cost of "cheaper" generic drugs

Much of the enthusiasm for generic prescribing is based on a shortsighted view that fails to take such long-term issues into account. While cost is an important factor, pharmaceutical research, the quality of medicine, and future generations of patients must all be considered.

Settling for cheaper drugs today could deprive you and your patients of the drugs they may need tomorrow.

ROCHE®

To encourage imitation is to discourage innovation

Doctors and nurses

I have just read the editorial by Harvey M. Andre, MD, in *Michigan Medicine*, November 1980 entitled "Nursing Profession and Medical Practioners." I wholeheartedly agree with Doctor Andre's point of view and have been very active in trying to provide a resolution to what I see as an increasingly important problem regarding nurse practioners.

I would like to use your statement to support these contentions at a meeting of a task force on physicians assistants and nurse practioners for the AMA. I represent the Council on Medical Education on the tri-council task force which includes representatives from the Councils on Medical Services and Legislation.

We anticipate having our report for the AMA House of Delegates meeting in July 1981. I hope that your opinion will be the one that will sway the day. Thank you.

E. James Potchen, MD
Professor and Chairman
Department of Radiology
Michigan State University
East Lansing

MPMLC

I would like to share with you how happy the directors and staff of Michigan Physicians Mutual Liability Company have been with several actions that MSMS has taken in the last few months. The formal endorsement, the outstanding treatment at the MSMS Scientific Session, and the attitude taken relative to advertising in the MSMS journals have all had a positive affect on our marketing efforts and are most appreciated.

In this regard, I would advise you that as of November 21, 1980, we had 3,441 insureds for professional liability and over 150 insureds for Medgard. Also, you should be alerted to the fact that we are continuing to require the MSMS membership as a pre-requisite for obtaining insurance and last week non-renewed a physician because he no longer was a MSMS member.

MPMLC will continue to strive to be all that MSMS had hoped as we solve the individual insurance needs of many of your members and bring competition to the market place. For example, Medical Protective has filed to offer $1,000,000/$1,000,000 limits. As you know, this is the second time that your company has forced competition to offer higher limits than had previously been available. Please do not hesitate to advise individual members of the (MPMLC) Board or me if there is something that MPMLC might be doing that it is not presently doing.

Bill Cheeseman, President
Michigan Physicians Mutual
Liability Company
East Lansing

Doctor Reizen

I read with interest the article regarding Maurice S. Reizen, MD. I would be very interested to know who Doctor Reizen's top bureau chief is and also what his salary is. I should also like to know how much training he has had in excess of the amount of training Doctor Reizen has had, to warrant a difference of $27,000 per year in salary.

Thank you in advance for this information.

Arno W. Weiss, MD
Saginaw

Editor's note: When Doctor Reizen resigned, his top bureau chief was R.G. Rice, MD, chief, MDPH Bureau of Personal Health. He made $82,663 per year, in contrast to Doctor Reizen's $60,000 per year. The salary differential has nothing to do with training. It is due to the fact that the Bureau posts are filled through the Civil Service System, which awards merit increases and cost of living boosts. The state's department heads, however, are governor-appointed, with salaries determined by legislative appropriation. Thus, the bureau chief's salary reflects a yearly percentage increase determined by the Civil Service Commission, while the department head's compensation depends on annual appropriations. Doctor Reizen, coincidentally, recently took the post held by Doctor Rice, who has just retired.

MSMS virtues

This will replace a 3½-page letter that I wrote last week upon receiving my last copy of *Michigan Medicine*. The information regarding the recruitment committee to institute a campaign for new members for MSMS is what prompted this communication.

In the past I have noted numerous articles in your journal devoted to the "virtues" of MSMS. Since I live in the western part of the state, I have many times questioned the value of this organization. But I continue to hope that it does accomplish things which are not always publicized in *Michigan Medicine*.

I will not bore you with complaints about the complete orientation of the society to the southeastern part of the state, particularly in reference to the practices of Michigan Medical Service and the support from the hierarchy of MSMS dominated by physicians from that area.

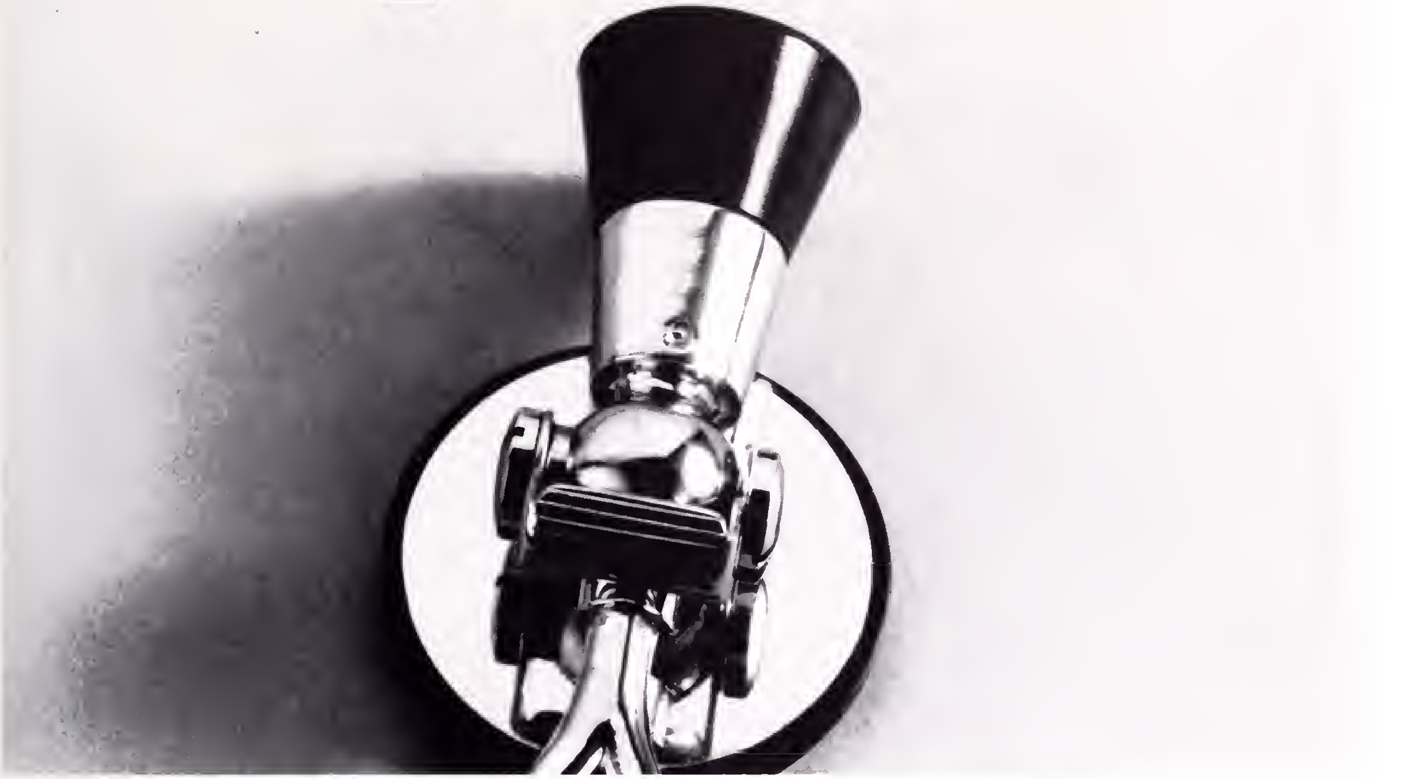
I would point out that MSMS *may* influence legislation *but* my license to practice is considerably higher than it was when I joined the Society 25 years ago. I know that my dues have increased steadily. I have seen the office building of MSMS which is attractive physically but like many architectural monuments, a somewhat costly edifice. Perhaps MSMS would not have to sell itself if it did something.

I will undoubtedly continue to belong to this organization but I do not feel that it is perhaps as grand as the descriptions and implications in your journal would seem to indicate. Perhaps the society should attempt to hear from people who are members of the Society but whose viewpoints are not represented in the House of Delegates.

I would hope that the journal would continue to publish information of value to members of our state society, but please quit telling us how great you are.

Robert M. Jesson, MD
Muskegon

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN



Healthy Competition
Makes A Healthier Market

**Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.**

Occurrence Coverage

Choice of limits— $100,000/ $300,000 or $200,000/ $600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

U.S. ARMY MEDICAL CAREER OPPORTUNITIES

We are looking for physicians who want to be physicians. We offer a practice that's practically perfect, where you work without worrying whether the patient can pay, without endless insurance forms, malpractice premiums, and cash flow worries, and where you prescribe, not the least care, not the defensive, but the best. If that is what you want, join the physicians who have joined the Army. Write us or call collect for the following information. We can offer:

Specialty Assignments
Residencies
Fellowships
Internships
Health Professions Scholarships
Employment Opportunities

CAPTAIN GARY PLACEK
AMEDD PROCUREMENT OFFICE
FEDERAL BLDG.
200 E. LIBERTY ST.
ANN ARBOR, MI 48107
(313) 668-2190

NEWS

By Bonnie L. Groff, MSMS staff

C. Allen Payne, MD, Ada, received the Distinguished Award for 1980 from the Michigan Association of the Professions at its Annual Fall Board Meeting and Awards Banquet. The award is given annually citing "of all professional persons he has served the professions best." . . . New president of the Jackson County Medical Society is **James W. Wilkins, Jr., MD**, Jackson. . . . **Robert Gregg, MD**, Detroit, and **R. Jack Chase, MD**, Grand Rapids, have been named to the Michigan Hospital Association Committee on Cost Containment. The committee formulates policy and implements programs to carry out the national voluntary effort to prevent unnecessary health care expenditures. . . . **John R. Ylvisaker, MD**, Bloomfield Hills, MSMS president, is serving on the Michigan Hospital Association's Advisory Panel to the Health Services Planning Project. The project was begun to more appropriately determine the future supply of health services. . . . At its recent meeting, the Michigan Society of Pathologists installed **Frank B. Walker, MD**, Grosse Pointe Farms, as president, and named **Theodore A. Reyman, MD**, Detroit as president-elect. . . . The Toxic Substance Control Commission of the State of Michigan has awarded a grant to **Kenneth Morton, MD**, Detroit, to study the chemical MOCA, an industrial product used as a chemical hardener in plastics. It is known to cause cancer in animals. . . . **James R. Acocks, MD**, Marquette, has received the V.K. Volk Award from the Michigan Society of Gerontology. The award is given annually to a state leader in elderly health care. . . . New president of the Central Association of Obstetricians and Gynecologists is **David G. Anderson, MD**, St. Joseph. . . . **Guy H. Earle, MD**, Gladstone, has received a Parke-Davis Teacher Development award from the American Academy of Family Physicians to help finance his interest in the part-time teaching of family practice. Doctor Earle was selected from a field of 72 candidates on the basis of scholastic achievement, leadership qualities and interest in part-time teaching of family practice. . . . **David Amos, MD**, Muskegon, was recently elected president of the Muskegon Medical Foundation. New vice president is **James Barnes, MD**, Muskegon. The foundation was set up by the Muskegon County Medical Society to aid medical and scientific projects. . . . Retiring after years of outstanding service to MSMS is **Kenneth Johnson, MD**, Lansing. Doctor Johnson is past MSMS president, secretary, and speaker of the House of Delegates. The Society has named the first floor lounge in its East Lansing headquarters building the Kenneth Johnson Room. . . . **Paul R. Lichter, MD**, Ann Arbor, was elected by the American Academy of Ophthalmology to the office of Secretary for Programs, a position giving him responsibility for the scientific program and exhibits presented at the Academy's annual meeting. . . . **Fleming Barbour, MD**, Flint, was honored by the Michigan International Council for providing eye care and glasses for the needy in the Third World, for setting up clinics and treating poor people in Honduras, and for his contributions in the Flint area. The International Council is a non-profit corporation that serves as a center for international voluntary action and as an information clearinghouse for more than 100 world affairs organizations in Michigan. . . . **Larry J. Sell, MD**, Detroit, is new director of the primary care center at the Detroit Medical Center's new Detroit Receiving Hospital and University Health Center. . . . **Federico G. Mariona, MD**, Detroit, is new director of obstetrics and chief of the division of maternal and fetal medicine at the Detroit Medical Center facility. Doctor Mariona will also serve as the director of the perinatal center at Hutzel Hospital. . . . **Edward A. Krull, MD**, chairman of the department of dermatology at Henry Ford Hospital, was recently elected to the board of directors of the Foundation for International Dermatologic Education.

Leadership

It took time to achieve it
It takes dedication to keep it

Purepac became the largest generic drug manufacturing facility in the United States by providing high quality generic pharmaceuticals at the lowest possible cost. We know that to be on top tomorrow, we've got to stay a few steps ahead today. Here are some of the steps we've already taken:

- **Full-time Medical Vice President with Supporting PhD Staff**
- **ANDA/Patent Review Departments**
- **State Formulary Manager**
- **Regulatory Affairs Department**
- **Comprehensive Advertising and Marketing Support Programs**

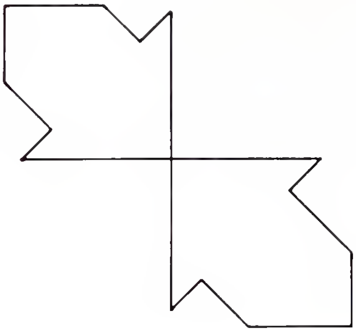
It took Purepac 50 years to achieve this leadership position. And we're determined to provide you with even more quality products and dedicated services in the next 50 years.

PUREPAC PHARMACEUTICAL CO.
Division of Kalipharma, Inc., Elizabeth, N.J. 07207

1930-1981
Celebrating over 50 years of industry leadership.

GN-1080

MEDICAL NEWSFRONTS



Baby's best diet is mother's milk and no solid food until five to six months of age, according to a recent study described in the December *Journal of The American Dietetic Association*.

Experimental evidence indicates that infants fed formula or cow's milk may actually require higher intakes of some nutrients. It has been found, for example, that infants absorb about 50 percent of the iron in breast milk but only four to 10 percent of the iron from cow's milk and fortified formulas. Likewise, about two-thirds of the calcium in human milk but only 25 to 30 percent in cow's milk is absorbed by the infant.

Even formula-fed infants do better without solid foods in the first five or six months, the authors say, because vegetables fed at four months of age appear to inhibit absorption of iron both from formula and human milk.

Sodium intake of infants on formula or formula and solid food exceeded the advisable intake per day at eight and 12 weeks, the research shows.

The investigators are Diane W. Marlin; Mary F. Picciano, PhD, and Emily C. Livant, of the Department of Foods and Nutrition, School of Human Resources and Family Studies, College of Agriculture, University of Illinois, Urbana.

Nine cases of penicillinase-producing Neisseria gonorrhoeae (PPNG) were reported during November in Michigan. Five cases were diagnosed in Genesee County and four in Detroit. Prior to this outbreak, only seven cases had been found in Michigan since the first PPNG case was identified in the United States in March 1976.

Most PPNG has been detected in patients who have not responded to penicillin therapy. This outbreak emphasizes the need for test-of-cure cultures to be done on *all patients* three to seven days following treatment for gonorrhea. Any positive post-treatment gonorrhea culture should be tested for B-lactamase.

Although most PPNG cases in the past have been associated with overseas travel, the current cases in Michigan underline a national trend for PPNG to become more of an endemic problem.

Specific treatment and case management recommendations are available through county health departments or the Michigan Department of Public Health-Venereal Disease Division.

Promising new cancer drugs will be tested in clinical trials at University Hospital.

The trials are being funded by the National Cancer Institute through a $1.3 million, five-year grant to the Division of Hemotology/Oncology at the U-M Medical School. The trials will attempt to establish new drug therapy for tumors where previous drug programs have been only marginally effective and for tumors which have become resistant to standard drugs. The types of disease involved include cancer of the breast, colon, lung, head and neck, and the lymphatic system.

The U-M is one of only four institutions in the country to be selected from 30 that applied for this research, according to Albert F. Lobuglio, MD, director of hematology/oncology.

A new $8 million library and learning center has gone into operation on The University of Michigan Medical Center offering future physicians and nurses more access to scientific knowledge and training than ever before.

Built with a combination of state, federal and private funds, the library is named after its largest private contributor, A. Alfred Taubman, board chairman of The Taubman Company, Inc., Troy.

With a total of 960 study stations, the new library building has a greatly-enlarged capacity to serve its 4,000 primary users. The former library had only 244 seats.

The new structure also incorporates an expanded Learning Resource Center moved from a smaller area in another building.

Lansing's Sparrow Hospital Office of Medical Oncology, under the direction of Francis A. Breen, Jr., MD, has begun treating cancer patients with interferon, an anti-viral replication protein.

The scientists and medical technologists in Sparrow Hospital's Department of Laboratories, W. E. Maldonado, MD, director, are responsible for production of the interferon.

The production of interferon at Sparrow Hospital represents an extension of a program which began a number of years ago with the Laboratory's involvement in therapeutic white blood cell research and related investigational efforts.

It is anticipated that 50 patients will be treated with interferon in the first six months of the Sparrow Hospital program.

Three categories of patients will be considered: patients with advanced malignancies felt to be potentially responsive to interferon — such as breast cancer, melanoma, multiple myeloma and non-Hodgkin's lymphoma; patients at high risk for recurrence following primary cancer surgery for such malignancies as advanced colon cancer and melanoma; and patients with advanced cancers that have failed to respond to all conventional modes of therapy and who have a reasonable chance of responding to interferon. In all but the last group described, interferon will be used in addition to the patient's usual treatment, not in place of it.

1953.

- General Dwight D. Eisenhower was inaugurated President of the United States; his vice president was Richard M. Nixon.
- The Korean armistice was signed to end the Korean War.
- Not one home owned an electronic calculator or color TV.
- It cost 3¢ to mail a letter.
- The Studebaker was the "new American car with the European look."
- Jacqueline Bouvier was engaged to U.S. Senator John F. Kennedy; **and**
- **the Stratton Agency began serving the Michigan State Medical Society!**

We have appreciated your participation and support over the past 27 years. If you would like additional information about our services, we would be happy to hear from you.

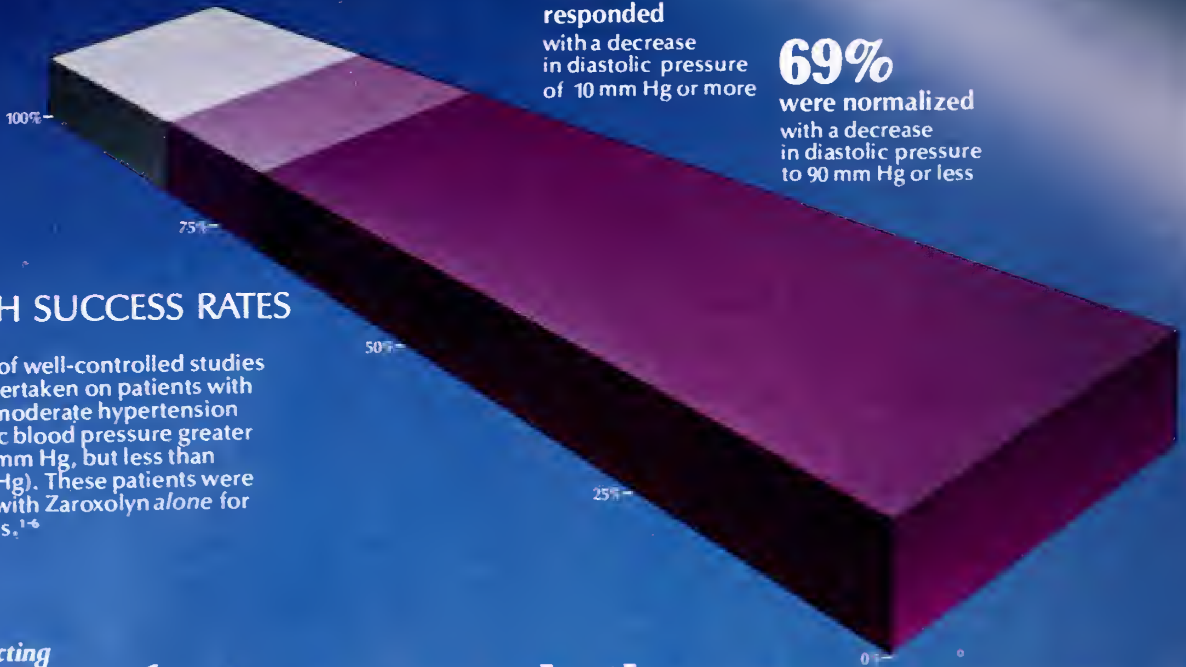
STRATTON-CHEESEMAN & ASSOCIATES, INC.
1305 Abbott Road, P.O. Box 1563
East Lansing, Michigan 48823

800-292-1966

For Step-1 diuretic therapy that

start with...

120
115
110
105
100
95



81%
responded
with a decrease in diastolic pressure of 10 mm Hg or more

69%
were normalized
with a decrease in diastolic pressure to 90 mm Hg or less

- HIGH SUCCESS RATES

A series of well-controlled studies was undertaken on patients with mild to moderate hypertension (diastolic blood pressure greater than 90 mm Hg, but less than 120 mm Hg). These patients were treated with Zaroxolyn *alone* for 6 months.[1-6]

Long-acting
Zaroxolyn®...As much therapy as many of
(metolazone) Pennwalt

improves the bottom line…

stay with

Long-acting

Zaroxolyn®

(metolazone) Pennwalt

2½ mg, 5 mg, 10 mg tablets

- NO TOLERANCE TO THE ANTIHYPERTENSIVE EFFECT NOTED IN LONG-TERM USE[1,4,5]
- WELL-TOLERATED ANTIHYPERTENSIVE THERAPY[1] . . . *ONCE DAILY* TO ENCOURAGE PATIENT COMPLIANCE

your hypertensive patients may ever need

Please see following page for prescribing information.

Long-acting
Zaroxolyn®
(metolazone) Pennwalt

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative The following is a brief summary **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease Routine use in pregnancy is inappropriate **Contraindications:** Anuria, hepatic coma or precoma, allergy or hypersensitivity to Zaroxolyn **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone Hypokalemia may occur, and is a particular hazard in digitalized patients, dangerous or fatal arrhythmias may occur Azotemia and hyperuricemia may be noted or precipitated Considerable potentiation may occur when given concurrently with furosemide When used concurrently with other antihypertensives, the dosage of the other agents should be reduced Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia Administration to women of child-bearing age requires that potential benefits be weighed against possible hazards to the fetus Zaroxolyn appears in the breast milk Not for pediatric use **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered Patients treated with diuretics or corticosteroids are susceptible to potassium depletion Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function Insulin requirements may be affected in diabetics Hyperglycemia and glycosuria may occur in latent diabetes Chloride deficit and hypochloremic alkalosis may occur Orthostatic hypotension may occur Dilutional hyponatremia may occur Zaroxolyn 10 mg tablets contain FD&C Yellow No 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals Although the overall incidence of FD&C Yellow No 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg Dosage adjustment is usually necessary during the course of therapy **How Supplied:** Tablets, 2½, 5 and 10 mg

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division **2.** Van Hoose MC, Cutler RE Antihypertensive efficacy of metolazone (Zaroxolyn®) alone and combined with reserpine in treatment of essential hypertension *Curr Ther Res* 20 266-276, 1976. **3.** Cangiano JL, Campos JA, Trevino A IV, et al The effects of metolazone in the long-term treatment of essential hypertension *Curr Ther Res* 16 778-785, 1974 **4.** Cangiano JL. Effects of prolonged administration of metolazone in the treatment of essential hypertension *Curr Ther Res* 20 745-750, 1976 **5.** Dornfeld L, Kane RE Metolazone in essential hypertension The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18 527-533, 1975 **6.** Materson BJ, Oster JR, Perez-Stable EC Antihypertensive effects of metolazone (Zaroxolyn) *Curr Ther Res* 16 890-896, 1974

Rx DIVISION
PENNWALT
[illegible]

A-254

Retiring State Sen. Ray Kehres, right, was honor at a recent reception sponsored by the MSM Medicaid Liaison Committee. With Mr. Kehr above, are David Siegel, MD, center, who shar many a Medicaid budget discussion with Se Kehres, and also is retiring as committee chairm and Republican state party chairman and form legislator, Melvin Larsen.

Associate Medical Director

One of Chicagoland's largest manufacturing plants is seeking a physician for its staff.

This plant's Medical Department has a staff of four (4) physicians, including a director, participating in a comprehensive program of occupational medicine in a well equipped and modern medical facility. Opportunities for professional growth and advancement are excellent.

The Medical Department includes a fully staffed complex with an x-ray unit, laboratory and clinic facility. It has a full range of medical activities including traumatic preplacement and consulting services. It also includes an Occupational Hygiene Division having a comprehensive program for evaluation of environmental exposure.

An outstanding company paid fringe benefit package is included. Salary available is open depending upon the candidate's experience.

Normal working hours are 8:00 A.M. to 5:00 P.M. Monday thru Friday. A wide variety of desirable locations in which to live are available.

Reply in confidence to: Box 10, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

equal opportunity employer m/f

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® /5 Buccal mg /10 Oral mg. /25 Oral mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Attention Doctors and Medical Laboratories

Now receive Blue Shield payments every eight days!

- Patient Insurance
- Accounts Receivable
- Terminal Setup
- Magnetic Tape Billing
- Processing and Handling

Daily Delivery to Blue Cross-Blue Shield & Medicare

All Other Insurance Companies

Dempsey Data Service

G7252 Fenton Road
Grand Blanc, Michigan 48439

(313) 738-2280

CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Feb. 14, A Practical Endocrinologic Approach for the Diagnosis of Thyroid and Adrenal Disorders. Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **For:** All interested physicians. **Contact:** T. A. Reyman, MD, Department of Pathology, Mt. Carmel Mercy Hospital, Detroit, MI 48235. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 16-20, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine Division of Continuing Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

Date: Feb. 18-19, Problems & Perspectives in Pulmonary Infections. Location: Boyne Highlands. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202, 313/876-1463. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 20-22, Practical Otolaryngology. Location: Dearborn Inn, Dearborn. **Sponsor:** Wayne State University Office of CME. **For:** All interested physicians. **Contact:** Ms. Anita Tompkins, 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: Feb. 21, Rheumatology Update. Location: Muskegon Osteopathic Hospital. **Sponsor:** Department of Osteopathic Medicine, Michigan State University. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved For:** 6 hours of Category I Credit.

Date: Feb. 22-27, Emergencies In Medicine. Location: Boyne Falls. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Theresa Sokol, WSU School of Medicine, Department of Surgery, 6C University Health Center, 4201 St. Antoine, Detroit, 48201. **Approved for:** 23 hours of Category I Credit.

Date: Feb. 23-Mar. 2, St. Thomas Adventure. Location: St. Thomas, Virgin Islands. **Sponsor:** Michigan State University College of Osteopathic Medicine Alumni and the MSU College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 20 hours of Category I Credit.

Date: Feb. 23-27, Second Annual Boyne Winter Imaging Seminar. Location: Boyne Highlands, Harbor Springs. **Sponsor:** William Beaumont Hospital. **For:** Radiologist, obstetrician/gynecologists, surgeons and internists. **Cost:** $200. **Contact:** Robert L. Bree, MD, program director, 313/288-7046. **Approved for:** 29 hours of Category I Credit.

Date: Feb. 25, Update on Resistant Hypertension. Location: Henry Ford Hospital's Education & Research Center, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** $30. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 3½ hours of Category I Credit.

Date: Feb. 25, The Person with Multiple Sclerosis. Location: Borgess Medical Center. **Sponsor:** Southwestern Michigan Multiple Sclerosis Society and Borgess Hospital. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Cost:** $25 for physicians, $10 for others. **Contact:** Charles L. Zeller, Jr., MD, Director CME, SMAHEC, 252 East Lovell, Kalamazoo 49007. **Approved for:** 6 hours of Category I Credit.

Date: March 4, Adolescent Gynecology and Obstetrics. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: Mar. 8, 3rd Annual Pain Conference, "Stress and Its Effect on Musculoskeletal Pain." Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 7 hours of Category I Credit.

Date: March 12, Seminar on Long Term Care Standards. Location: Troy. **Sponsor:** Joint Commission on Accreditation of Hospitals and Michigan Hospital Association. **For:** All interested physicians. **Contact:** Maryanne Butt, Michigan Hospital Association, 2213 E. Grand River, Lansing, 48912. 517/484-7441. **Approved for:** 7½ hours of Category I Credit.

Date: March 12, Treatment of Serious Infections Due to Gram-Negative Bacteria. Location: Henry Ford Hospital's Education & Research Center, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: March 12-13, Current Topics in Clinical Chemistry. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School, Departments of Pathology and Postgraduate Medicine and Health Professions Education. **For:** All interested physicians. **Cost:** $110. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 13½ hours of Category I Credit.

Date: March 14, Renal Manifestations in Systemic Disease. Location: Henry Ford Hospital's Education & Research Center, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: March 17-20, Birth Defects: Biology, Recognition, and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of

continued on page 82

I'M A PHYSICIAN,

NOT
A BILL COLLECTOR"

What do you do when a patient won't pay? Call on I.C. Systems, the approved collection service that is as professional as you are. While maintaining good will for you in the community, I.C. Systems clears up bad debts in an ethical, efficient and effective manner. Mail this coupon today to learn how...

The System
Works

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ______________________________

Address ______________________________

City ______________________________

State ____________________ Zip __________

Signature ______________________________

Michigan Medical School, Center for Human Growth and Development, the Department of Pediatrics and The Department of Postgraduate Medicine. **For:** All interested physicians. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Mar. 22, 4th Annual Pediatrics Conference. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Department of Pediatrics, Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 7½ hours of Category I Credit.

Date: March 30-31, Emergency Psychiatry. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **For:** All interested physicians. **Contact:** Towsley Center for CME, G-2111, Box 057, University of Michigan, Ann Arbor, 48109. 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: April 1-4, Aesthetic and Reconstructive Surgery of the Head and Neck. Location: Campus Inn, Ann Arbor. **Sponsor:** Department of Otolaryngology, University of Michigan Medical Center. **For:** All interested physicians. **Cost:** $500. **Contact:** Shan R. Baker, MD, Dept. of Otolaryngology, University of Michigan Medical Center, Ann Arbor, 48109. **Approved for:** 28 hours of Category I Credit.

Date: April 11, Breast Cancer. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 8 hours of Category I Credit.

Date: April 11-12, Conception and Misconception: Important Endocrine Problems Affecting Women. Location: Henry Ford Hospital's Education & Research Center, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 12 hours of Category I Credit.

Date: April 15, Pediatric Seminar V. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22101 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: April 22-24, Computerized Treatment Planning Systems Symposium. Location: Buerki Auditorium, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** $150. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 19½ hours of Category I Credit.

Date: April 23-25, Critical Care Symposium. Location: Wayne County Medical Society Headquarters. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Theresa Sokol, WSU School of Medicine, Department of Surgery 6C University Health Center, 4201 St. Antoine, Detroit, 48201. **Approved for:** 15 hours of Category I Credit.

Date: April 25-29, Advanced Muscle Energy Tutorial. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Date: April 27-29, Echocardiography — State of the Art. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan Heart Association and the American Heart Association Council on Clinical Cardiology. **For:** All interested physicians. **Contact:** Michigan Heart Association, P.O. Box 160-LV, Lathrup Village, 48076. 313/557-9500. **Approved for:** 15 hours of Category I Credit.

Date: May 9, Testicular Biopsy in Fertility Disorders and Unusual Pathologic Conditions of the Testes and Adnexa. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Michigan Society of Pathologists. **For:** All interested pathologists. **Contact:** Willys F. Mueller, MD, Department of Pathology, Hurley Hospital, Flint, 48502. **Approved for:** 3 hours of Category I Credit.

Date: May 14, Major Problems in Adolescence. Location: Kalamazoo Hilton. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** $55. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 16-18, Michigan Dermatological Society Central States Meeting. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Dermatological Society. **For:** All dermatologists. **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hours of Category I Credit.

Date: May 20, Family Practice Update. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 1-5, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
Since 1899
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

DETROIT OFFICE
R. K. Wind, J. K. Galloway, T. A. Weisman, and W. M. Backus, Representatives
6785 Telegraph Road, Suite 350, Birmingham 48010
Telephone (313) 647-6640
GRAND RAPIDS OFFICE: G. J. Howarth, Representative
143 Cortland Avenue, Rockford 49341, Telephone (616) 866-9395

In G.I. therapy

Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer*
and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

Roche Products, Inc.
Manati, Puerto Rico 00701

"We're together because Dr. Benson recommended home health care."

Home health care is an excellent alternative when your patients cannot fully care for themselves, yet do not need to be in a hospital or nursing home. They can enjoy the comforts of home and family while receiving the care they need, often at a cost far below that of institutional care. And you are always in full control of the plan of care.

Each year, thousands of people receive care at home from Upjohn HealthCare Services.℠ We employ nurses, nurse assistants, home health aides, homemakers and companions.

We're the nation's leading private provider of home health care, with hundreds of offices throughout the United States and Canada. Many of our offices are licensed to provide services covered by Medicare.

Upjohn HealthCare Services is a service program of The Upjohn Company, a name you and your patients can trust. For free home health care information packets you can give to your patients, please send us the coupon below. Or call our office nearest you, listed in the white pages of your telephone directory.

Upjohn

UPJOHN HEALTHCARE SERVICES℠

Let us help you tell your patients about home health care.

Please ☐ send me 10 free home health care information packets
☐ have your service director call me

Name______________________________
Address ____________________________
City _______________State_____Zip______

Mail to: Upjohn HealthCare Services
Dept. SJG
3651 Van Rick Drive
Kalamazoo, Michigan 49002

HM-6743 © 1981 Upjohn HealthCare Services, Inc.

MEETINGS

MSMS, AMA, MSMS/A and medical assistants

Feb. 20-Mar. 7 — MSMS/Intrav South African Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

Mar. 11 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Mar. 11 — MSMS/A Legislative Day, Civic Center, Lansing, contact: Caroline Rich, MSMS headquarters.

Mar. 25-26 — MSMS Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

Apr. 9 — MSMS Conference on Sports Medicine, Western Michigan University Student Center, Kalamazoo, contact: Mert Scholten, MSMS headquarters.

Apr. 23-26 — Annual Meeting, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn, Lansing, contact: Caroline Rich, MSMS headquarters.

Apr. 27-29 — 55th Annual Convention, MSMS/A, Marriott Inn, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

May 1-3 — MSMS House of Delegates, Troy Hilton, contact: Richard Campau, MSMS headquarters.

May 5-14 — MSMS/Intrav Canadian Rockies Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

June 7-11 — Annual Meeting, American Medical Association, Chicago.

July 16-19 — MSMS Council, Grand Traverse Hilton, contact: Warren Tryloff, MSMS headquarters.

Sept. 9 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 21 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

Feb. 26 — Council meeting, Michigan Psychiatric Society, Marriott Inn, Ann Arbor, contact: Helen Schulte, MSMS headquarters.

Mar. 11 — Membership meeting, Michigan Dermatological Society, Wayne State University, Detroit, contact: Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067.

Mar. 14-15 — Regional Conference on the Impaired Professional, Hilton Inn North, Worthington, OH, contact: Marcelyn Ireland, MSMS headquarters.

Apr. 6 — 60th Annual Beaumont Lecture, Wayne County Medical Society headquarters, contact: WCMS, 313/567-1640.

Apr. 23 — Council Meeting, Michigan Psychiatric Society, Detroit, contact: Helen Schulte, MSMS headquarters.

Apr. 30 — Annual Meeting, Michigan Society of Thoracic Surgeons, Hyatt Regency Dearborn, contact: Rodman E. Taber, MD, 30050 Hoover Road, Warren, 48093.

AN ATTRACTIVE ALTERNATIVE TO PRIVATE PRACTICE — AIR FORCE MEDICINE

Did you go to medical school to become a doctor or an office manager, supply clerk, or repairman? If you want to concentrate on your medical practice and leave the administration to someone else, then Air Force medicine can be an attractive alternative to your private practice. You see, the Air Force uses a group practice system of health care. This system allows maximum contact between patient and physician with a minimum of administrative responsibilities. Nurses and technicians take care of the paperwork while you take care of the patients. You'll get to use the skills gained through years of education; to stay abreast of new methods and techniques; and, for qualified physicians, to specialize. These benefits, along with our excellent employment package, make Air Force medicine an attractive alternative to private practice. Find out how you can be a part of the Air Force health care team. We'll answer all your questions promptly and without obligation.

Contact YOUR AIR FORCE REPRESENTATIVE AT 23400 Michigan Ave., Village Plaza, Dearborn, MI, (313) 562-7018; in Ann Arbor, MI (313) 668-2407; in Lansing, MI (517) 372-3133.

AIR FORCE
A great way of life

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

PATHOLOGY RESIDENCY — Grad Year I — Unexpected opening for July 1, 1981 in fully approved four year program in large community teaching hospital in Detroit. Write or call, Dept. of Health Education, Saint John Hospital, 22101 Moross Rd., Detroit, MI 48236. (313) 343-3875.

FAMILY PHYSICIAN to assume well established family medical practice in a pleasant thriving community on Lake Michigan. Plentiful outdoor recreation, near colleges. 120 bed hospital, excellent consulting specialists. Contact Frank L. Groat, MD, 631 Franklin, Grand Haven, Michigan, 49417. Phone 616-842-8120 or 842-6126. Relocating soon to a warmer climate.

Ear, Nose and Throat practice available. Established for the last 40 years. Located in Southfield, Michigan, in medical building adjacent to hospital in prime medical/commercial area. Excellent opportunity for new practitioner, or for established surgeon to expand own practice. For information call (313) 569-6569.

PEDIATRIC RESIDENCY — GRAD YEAR II — Unexpected opening for July 1, 1981, in fully approved three year program in large community teaching hospital in Detroit. Write or call Dept. of Health Education, St. John Hospital, 22101 Moross Rd., Detroit, MI 48236. (313) 343-3875.

(Medical) Specialist — Ob/Gyn or Other. Grosse Pointe Area, five room suite. Other tenants are family practice clinic and radiologist with ultrasound, fluoroscopy and nuclear medicine. Full maintenance with janitorial service. $500.00 per month. 16840 E. Warren — Steven at (313) 882-7060.

Lovely Southwestern Climate — Multispecialty group seeking anesthesiologist. Substantial guarantee. Contact Talton L. Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, TX, 79925. Phone 915/592-0201.

Lovely Southwestern Climate — Multispecialty group seeking Obg physician. Substantial guarantee. Contact Talton L. Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, TX, 79925. Phone 915/592-0201.

Board certified physician interested in group practice in a rapidly growing community in southeastern Michigan, affiliated with a 595-bed community teaching hospital. Should have 3 to 5 years practice experience. Four positions available. Send curriculum vitae to: President's Office, Oakwood Hospital, 18101 Oakwood Blvd., Dearborn, Michigan 48124.

OB-GYN: Board eligible or certified to join busy practice in a beautiful resort area close to Detroit. Excellent office located one mile from hospital. No investment required. Equal work. Salary open. Partnership available after first of year. M. I. Sabbagh, MD, P.O. Box 163, St. Clair, 48079. 313/329-7000.

MUNSTER, IN. — Family Phys., Gen. Internists, ENT, Orthopaedists, Gen. Surgeons needed for large midwest multi-specialty group. Competitive first year salary with opportunity for early partnership; all fringes clinic paid. Excellent opportunity to inherit existing and develop your own practice. Call or send CV to: T. R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN. 46321. (219) 836-5800.

PART-TIME PHYSICIAN needed to do routine physicals to assess donor suitability for plasmapheresis. Good position for older physician looking to slow down. Malpractice coverage provided. Contact Thomas Anderson at American Plasma Management, Kalamazoo, MI. Phone 616/381-0086.

LOCUM TENENS — EMERGENCY DEPARTMENT OPENINGS. Our group is serving emergency departments throughout the country with openings for locum tenens physicians. Flexible schedules and attractive locations available. Malpractice insurance and competitive hourly rates are offered. We're on the move — Come grow with us. Contact ECI, Suite 115, 1 Windemere Place, Petoskey, Michigan 49770. Out of State 1-800-253-7092, Michigan 1-616-347-1580.

Positions available in Multi-Specialty Clinic and Emergency Departments throughout the U.S. Guaranteed salary with full benefits. Come grow with us — We're on the move. Contact ECI, Recruitment Division, Suite 115, 2240 S. Airport Rd., Traverse City, MI 49684, or call in Michigan 1-800-632-3496, Out of State 1-800-253-1795.

GROW WITH US IN SUNNY ARIZONA — The INA Healthplan needs physicians in family practice and most specialties in Tucson and Phoenix. Competitive salaries and comprehensive benefits including a professional development program, retirement plan, and group incentive bonus are provided. If team ir
teraction and casual living interest you, sen
your CV to: Professional Relations, IN
Healthplan, Inc., 6115 North 7th Stree
Phoenix, AZ 85014.

**UNIVERSITY HEALTH SERVICES — MICH
GAN TECHNOLOGICAL UNIVERSITY** Healt
service seeks a replacement primary care me
ical director. The health facility is a medicall
oriented, ambulatory service, servicing a un
versity student population of 7,700. Annu
students visits are approximately 10,000. Lit
eral fringe, meeting allowance, and vacatio
benefits complement a competitive salary an
allow adequate enjoyment of the rural al
season recreation area. Contact Terry Kinze
MD, MTU Health Services, Houghton, M
49931. Phone 906-487-2435. Michiga
Technological University is an equal opportu
nity educational institution/equal opportunit
employer.

Ob/Gyn practice open in Mt. Clemens are
Present incumbent retiring when suitabl
qualified applicant applies to take over offic
Write O.W. Oughtred, MD, F.A.C.O.G., 3599
South Gratiot, Mt. Clemens, 48043.

**OBSTETRICIAN/GYNECOLOGIST, OP
THALMOLOGIST, ORTHOPOD, PEDIATR
CIAN** — needed in historic Marshall, Michiga
located half-way between Ann Arbor an
Kalamazoo. Beautiful town with a 77-bed acu
care hospital. City population of 7,500 an
service area population of 22,000. Admittin
staff includes; four (4) Family Practice Specia
ists, five (5) General Practitioners, two (2) Ge
eral Surgeons, and one (1) Internist. Willing
negotiate to attract a high caliber physicia
Contact: Rob Covert, Administrator, or Phil
Glotfelty, MD, Chief of Staff, Oaklawn Hospita
200 North Madison, Marshall, Michigan 4906
or phone 616-781-4271, extension 201.

Primary Care Physicians for independent fa
ily practice, internal medicine, and pediatric
North Central Wisconsin. Excellent clinic
facilities and assured support of independe
practitioners. P.O. Box 801, Neenah, Wisco
sin, 54956.

Positions With The State Of Michigan — Cu
rently taking applications for positions e
pected to be available in the future. Primari
interested in board certified or board eligib
internists with cardiology background. Offic
locations in Southfield, Lansing, and Travers
City. Also considering an office in Kalamazo
Salary in 50's with approximately 40% frin
benefits. An equal opportunity employer. A
inquiries treated confidentially. For further d
tails please write: Disability Determinatio
Service, P.O. Box 30011, Lansing, MI 48909,

EATHS

ermany E. Bennett, MD
etroit

ermany E. Bennett, MD, Detroit, ed Nov. 30 at the age of 77. Doctor ennett received his MD from leharry Medical College in 1932. He aintained a private practice in the etroit area since 1933 and was af-liated with Burton Mercy and outhwest Detroit hospitals.

arold J. Cawthorne, MD
t. Joseph

arold J. Cawthorne, MD, St. Joseph, ied Nov. 29. He was 82. Doctor awthorne earned his MD from the niversity of Illinois Medical School 1933. He maintained a private ractice in Benton Harbor from 1937 ntil his retirement in 1959. Doctor awthorne was a member of the merican Academy of Opthalmology nd Otolaryngology. He served as ce president of the Berrien County ledical Society and was affiliated ith Mercy and Memorial hospitals.

Benjamin Jeffries, MD
Grosse Pointe Park

Former MSMS Councilor Benjamin Jeffries, MD, Grosse Pointe Park, died Nov. 25 at the age of 66. Doctor Jeffries served on the board of directors of Blue Cross Blue Shield of Michigan and on the board of trustees of the Detroit-Macomb Hospitals Association. He was former chief of psychiatry at Detroit Memorial, South Macomb and Cottage hospitals. Doctor Jeffries was chairman of the MSMS Mental Health Committee and served as a councilor from Wayne County. He earned his MD from Wayne State University School of Medicine in 1941.

George G. Rieckhoff, MD
Detroit

George G. Rieckhoff, MD, Detroit, died Nov. 30. He was 89. Doctor Rieckhoff received his MD from Marquette University Medical School in 1916. He served as a captain in World War I. He was a fellow of the American College of Surgeons. He maintained a private practice in Detroit until his retirement in 1976 and was affiliated with Detroit Memorial Hospital.

John G. Slevin, MD
Grosse Pointe Farms

John G. Slevin, MD, Grosse Pointe Farms, died Nov. 18 at the age of 77. Doctor Slevin earned his MD from the St. Louis University Medical School in 1929. During World War II, he served as a colonel in the Army medical corps. Doctor Slevin was a fellow of the American College of Surgeons and the American Society of Abdominal Surgeons. He was affiliated with Grace Hospital. In addition, he served as co-editor of the Wayne County Medical Society's Detroit Medical News.

---

ll collect: Harry D. Nesmith, MD, Chief Medi-l Consultant (517) 373-7830. In Michigan, call ll free 1-800-292-2710.

ositions wanted

ocum Tenens — COMPHEALTH. Our medical oup can place a well-qualified physician in ur practice during your absence. For more formation call or write: Comprehensive ealth Systems, Inc., 175 West Second South, alt Lake City, UT 84101. (801) 532-1200.

rologic Surgeon seeks practice opportunity West Michigan, solo or group. University ained, board certified, 5 yrs. solo practice. eviously board certified anesthesiologist. nerican, University of Michigan graduate 959, christian, married 24 yrs., 5 children. chard M. Delnay, MD, 1646 Sam Houston Dr., arlingen, TX 78550.

liscellaneous

J SABLE RIVER-FRONT HOME. Year around treat. Prime trout fishing out your front door. nree acres with private trout pond. Enjoy eplace on cold days — Watch river drift by om cozy glassed-in living room. Completely rnished. Eight miles east of Grayling. Price 9,000. Terms available. Call Ruth Steffe, entury 21 River Country, 517/348-9868.

. Clair Michigan — Modern medical office, ear hospital, 1200 sq. ft., available January 981. Good growth location and pleasant liv-g. Ample parking. Reasonable rent. Call M. I. abbagh, MD, 1-313-329-7000.

ail, Colorado, available after January 5, 1981, ew three bedroom, 2½ bath condominium. eeps eight comfortably. Call Bob 334-6100.

Howell, Michigan — 8,000 sq. ft., medical-dental, available January, 1981, in attractively designed professional building. Complex conveniently located within walking distance of hospital which serves fastest growing county in state. For information, call evenings, 517/546-8895.

OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

INVESTMENTS: What tangible asset has returned over 40% per year compounded annually since 1972? Learn about rare coin investing, the prudent investment opportunity for KEOGH, IRA, profit sharing plans. Your hedge against inflation. Write for free investment brochure. John Frank Rare Coin Investments LTD., 3000 Town Center, Suite 1444, Southfield, MI 48033. 313-354-3666.

Medical Professional Office, Lansing, Michigan. Corner of Pennsylvania and May streets. Site plan approved by the city of Lansing for 3,600 square foot professional building. Conceptual plans done. Ready to apply your interior layout and construct to suit. Will build to lease to your specifications. Ideal location between Saginaw and Oakland in developing area six blocks from Sparrow Hospital. Purchase possible. Also 10,000 square feet of new office across from Delta Dental in Okemos, construction starting soon, 5,000 feet still available in this outstanding building. Others coming on with condominium purchase possible. Contact C. Wallin 517/349-0461.

Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury, two & three bedroom units. Near Boyne ski hills. $92,000-$96,500. Furnished unit rentals available for vacation year round. A.K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

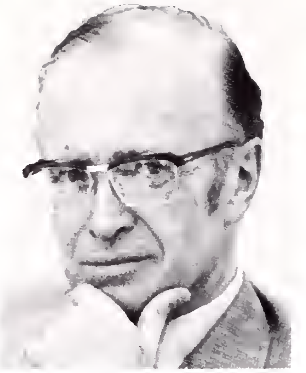
St. Thomas, U.S.V.I. Ocean front condominium villa. Sleeps 4-6. Three pools, free tennis, duty free shopping. List of local medical meetings available. Reduced air fares. 313/543-2970 or 542-7600.

St. Thomas, U.S.V.I. Condominium For Rent. Ocean Front. Two bedrooms, two baths, free tennis, three pools. Duty free shopping. List of medical meetings available. 313/543-2970 or 313/542-7600.

Hilton Head Island, SC. Ocean Villa, Captain's Cove in Palmetto Dunes Resort. Luxurious new villa, 150 yds. from beach. Lagoon backyard, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, pool, fishing, canoeing, biking, etc. Weekly, monthly. Call or write, 313/695-0356, 6236 Kings Crown Rd., Grand Blanc, MI 48439.

We have various quantities of medical equipment available in excellent condition. We buy, sell, trade, move. New equipment also available. Call Doctor Medical Resale, 313-569-4407, 9 am to 9 pm.

PRESIDENT'S PAGE



MSMS engaging the battle of medical cost containment

By John R. Ylvisaker, MD, MSMS President

The overriding goal of the health care industry is to make (and keep) sick people well and healthy. But the overriding goal of the healthy public is to reduce the cost of the process. Attendance at three recent national association meetings demonstrated the preoccupation of the industry and the public with cost and the attempts at control through reimbursement, health planning and regulation.

Each meeting produced a parade of non-*providers* speaking on their ideas, activities, and initiatives to control the cost environment which providers are then forced to live with. The beehive of superimposed busy-work is amazing, especially considering:

— the cost of such activity and the diverssion of health care dollars to non-health care activities.

— the interference with health industry productivity.

— the relative ineffectiveness of such activity.

— the number and variety of non-providers making decisions.

— and the almost complete failure to address the most fundamental problem: the absence of a self-regulating free market.

Who is doing what?

The *Federal government* (as extensively discussed) has attempted to control cost through federally mandated planning, gloved threats of federal "guidelines" and fund manipulation, and regulated programs bureaucratically administered.

State government has both yielded to federal dictates and expanded the regulatory approach through state-funded programs, certificate-of-need, ever-increasing rule-making of agencies and departments, and now legislation to control private corporations (BCBSM).

Insurers, including BCBSM, are in business to sell only the product which the public will buy and not what the public should buy. Like big cars, they sell big insurance as long as that's what industry and labor are buying. Very few are innovative with any change in the system.

Industry, now very aware that it is the major purchaser of health care, is finally beginning to re-trench and work toward change. Chrysler has been in the throes of trying to save $25 million by a self-insurance plan. The John Deere Company of Moline, Illinois is an excellent example of aggressive effort to effect changes in understanding and use with good education as well as by change in the reimbursement system with a company-assisted IPA. Strikingly, the voluntary effort exercised within the system of conventional insurance coverage has produced only moderate cost savings versus the much more dramatic savings within its cost-conscious IPA.

Labor unions in our major industries have been resistant to change from first dollar coverage demands. Prolonged strikes have been evidence. But recently, with the economic instability of their employers and the effect of excess cost on price competitiveness, there has been a glimmer of willingness to look at alternative reimbursement systems.

So what about providers?

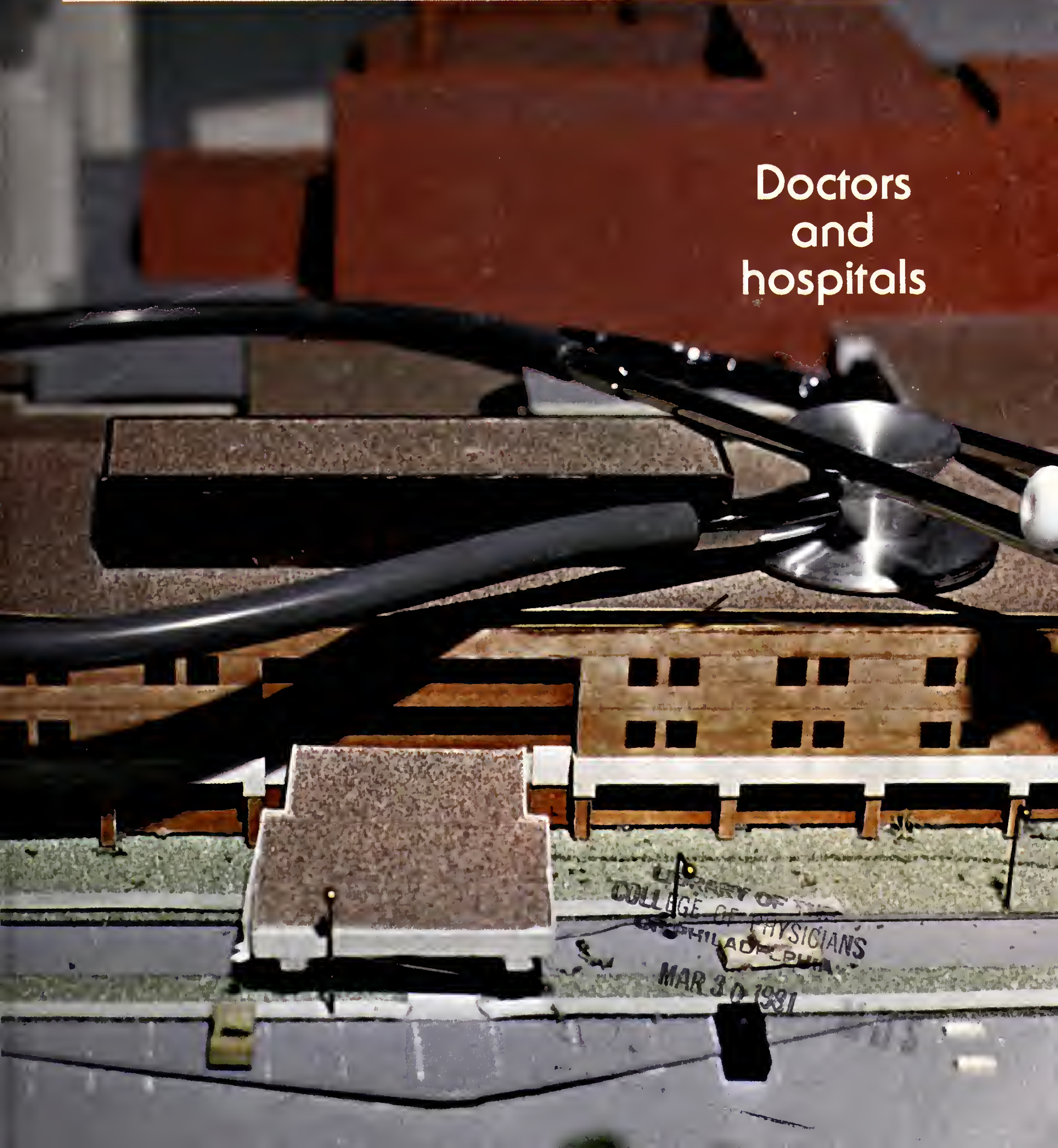
Generally, *providers* have been the beneficiaries of the present reimbursement system, have become accustomed to the way it functions, and have taken little initiative to restore cost-consciousness. The most touted initiative has been the VE (Voluntary Effort) Program. In all honesty, this has been a desultory effort at the grassroots level and has achieved only about a one percent estimated savings. Conversely, where providers have embarked on initiatives to change the way health care is paid for toward a cost-conscious system, costs of care have been substantially reduced.

MSMS is progressively moving with initiatives to change the system. We are constantly at work monitoring and molding regulation at the state level. We are interfacing with state departments and agencies over rules and function. We are pursuing the repeal of regulated health planning but with a constructive approach to replacement by voluntary planning.

Partnerships are being formed and strengthened with the specialty societies, with professional organizations and associations, and with third parties to make possible the cooperative development of new approaches. Lastly, a coalition with industry, insurers, labor and government is in the process of formation with Council support. If successful, this coalition may provide the vehicle for the major providers to engage the issues of change as equal partners or leaders rather than as passive reactors.

MICHIGAN MEDICINE

March 1981 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 80, No. 8



Doctors
and
hospitals

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
MAR 30 1981

1981 Conference on Sports Medicine

Thursday, April 9, 1981
Western Michigan University Student Union, Kalamazoo

Sponsored by Michigan State Medical Society

The Michigan State Medical Society will grant 6 hours of Category I continuing medical education credit toward the state requirements. AAFP prescribed credits for family physicians also will be awarded.

8 a.m.	*Registration and coffee*
9 a.m.	Welcome: Charles Zimont, MD, chairman, MSMS Sports Medicine Committee
9:10 a.m.	**Introduction and Opening Remarks** Doug McKeag, MD, conference chairman
9:20 a.m.	**"Physiology of Conditioning"** Jack Wilmore, PhD, Exercise Physiologist, University of Arizona, Tucson, Arizona
10:00 a.m.	**"Orthopedic Screening Exam"** Herb Ross, DO, Consulting Team Orthopedic Surgeon, Michigan State University
10:40 a.m.	*Coffee Break*
10:55 a.m.	**"Conditioning from the Athlete's Viewpoint"** Herb Lindsay, Runner, Top Ranking Road Racer in Nation, Boulder, Colorado
11:35 a.m.	**"Conditioning from a High School Trainer's Viewpoint"** Tom Mackowiak, A.T.C., East Lansing High School, East Lansing
12:25 p.m.	*Luncheon* — **"How I learned to like Sports Medicine"** Doug Weaver, Athletic Director, Michigan State University
1:45 p.m.	**"Injuries of Conditioning — Children and A lescents"** Dave Hough, MD, Family Physician, Dep ment of Family Practice, Division of Athl Medicine, Michigan State University
2:25 p.m.	**"Injuries of Conditioning — Adults"** Gerald O'Connor, MD, Team Orthopedic geon, University of Michigan, Ann Arbor
3:05 p.m.	*Coffee Break*
3:20 p.m.	**"Designing a Sound Conditioning Program** Jack Wilmore, PhD, Exercise Physiologist, versity of Arizona, Tucson, Arizona
4:00 p.m.	Panel Discussion
4:30 p.m.	**Summary and Closing Comments** Doug McKeag, MD

REGISTRATION FORM

Please return to: MSMS Sports Medicine Conference
PO Box 950, East Lansing, MI 48823 Phone: 517/337-1351

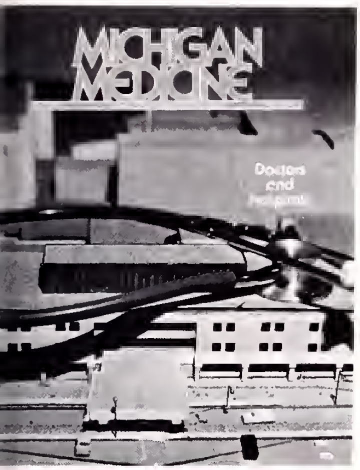
Name ______________________________

Address ______________________________

City ____________ **State** ____________ **Zip** ____________

Check one: (Registration fee includes lunch)

☐ **Physician ($20)** ☐ **Trainer ($15)** ☐ **Coach ($15)** ☐ **Other ($15)**



MICHIGAN MEDICINE
March 1981, Volume 80, Number 8

Special report

94 Hospitals are increasingly the focus of physicians' clinical lives. With greater involvement come greater opportunities for physicians and hospitals to cooperate, and to clash. MSMS is increasingly involved on the side of cooperation. For a report on MSMS involvement, and discussion of some of the issues, please see this month's special report; Judith Marr; William J. Downer, Jr.; Kenneth L. Urwiller, MD

Features

93 President's statement on radial keratotomy; John R. Ylvisaker, MD

100 MSMS looking for physicians' ideas on reducing medical care costs; R. Jack Chase, MD

102 PSROs' success limited only by physicians' determination and resolve; Daniel J. Fall, MD

105 Maternal Health Desk Reference Card No. 25, "Standards for Nutritional Care"

109 Ambulatory surgery continues to prove efficacious, economical; Paul T. Lahti, MD

112 After-hours pediatrics clinic saves on emergency room use; Sally A. M. Steinborn

114 The next MSMS president, James D. Fryfogle, MD, up close; Shelton Reece

116 Michigan doctor treats polar bear wounds, hunts for caribou on Baffin Island adventure; Orville Oughtred, MD

122 Michigan Board of Medicine disciplinary actions

134 Patient education key to prevention; Jeffrey Rich

Departments

90 In my opinion; James D. Fryfogle, MD

91 Letters

104 Health planning update

120 Medico-legal

127 Category I courses

128 Meetings

136 Medical newsfronts

138 Deaths

140 Classified ads

141 MSMS/A; Barbara Grennan

142 President's page; John R. Ylvisaker, MD

Thanks to our advertisers

Abbott Labs 132, 133
Active Homes 113
Ad Council 126
Advance Medical Research
  Center 131
Brown Pharmaceutical 139
Burroughs Wellcome 108, 135
Carlton Numismatics 104
CRT Management 103
I.C. System 121
International
  Conferences 135
Intrav 129
Eli Lilly 101
Marion Labs 137
Medical Protective 131
Michigan Physicians
  Mutual Liability Co. 110, 111
Marshfield Clinic 120, 128
ParaData of Michigan 123
Physicians Insurance
  Company of Michigan 119
Roche .... 92, 93, IBC, BC
Smith, Kline & French 107, 125
Stratton Cheeseman 99
U-M Dept. of Psychology 134

IN MY OPINION

Talking, listening save MD/hospital 'marriage'

By James D. Fryfogle, MD, Southfield

The marriage of "today's doctors" and "today's hospitals" is a strange, or maybe an estranged, union.

Is it a marriage for love, for fear, for money, or for power? Is it a union of convenience, of necessity, or a burden?

It's probably a mix of all and each individual union has its own recipe.

He, the Doctor, says, "so-called forward-looking hospitals are expanding business enterprises of the 'Health Care Industry.' They are system oriented with continuing market analysis. They are funded by tax exemption, insurance plans, government subsidy, and charity. This business aspect makes for some loss of the truly professional and charitable image. Some idealism has been dissipated and replaced by business management policy. Some of the systems created tend to be self-serving."**

She, the Hospital, indignantly replies, "the changing hospital care environment is largely responsible for these actions. The new prepaid health plans (HMOs) can effectively reduce hospital census. They are increasing all around us and are subsidized by government funds.

Certificate of Need legislation prevents the expansion of our income potential;

Cost containment legislation prevents our funding new services; and

Our hospital administrators are pressured to:

1. Compete aggressively for physicians for their staffs (all agree that physicians and their skills are the most important marketing tool for hospitals;)
2. Diversify out of acute inpatient care into a broader mix of medical services;
3. Develop captive distribution systems for control of patient flow;
4. Promote all institution services.

"Wait," *he, the Doctor*, interrupts: "You're breaking into the private practice of medicine. Expand your services? You already control the laboratories, the x-ray and the ambulatory surgery. Now you are building ambulatory care centers right in the neighborhoods where we practice. You pay no taxes and insurance companies pay you for what should be office calls."

"Now you just wait a minute," *she, the Hospital*, cries, "We pay the doctors who run our ambulatory centers a good salary. We stay open when your office is closed and we take care of all Medicaid patients. Also, patients come to us because we can refer them directly to specialties if they need them."

"Ha!" *he, the doctor*, says, "that's because you control the specialty doctors. You force them to be on call to your clinics and emergency rooms as a part of hospital staff membership. When a doctor signs your by-laws he must agree to accept assignment by the officers to 'taking call,' committee membership, and teaching duties. No educational institution in the world is like a hospital —

Doctor Fryfogle is MSMS president-elect and a member of the MSMS Committee on Publications.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
James H. Tisdel, MD, Port Huron, Chairman
Busharat Ahmad, MD, Marquette
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editoria board of *Michigan Medicine* and advises the editors in the conduct and policy o the magazine, subject to the policies o the MSMS Council.

Neither the editors nor the state medica society will accept responsibility fo statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the write and not necessarily official positions o the society. Products and services advertised in *Michigan Medicine* are neithe endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293 is the official journal of the Michigan State Medical Society, published unde the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and a additional mailing offices. Yearly subscription rate, $20.00; single copies $1.50. Additional postage: Canada, $1 pe year; Pan-American Union, $2.50 pe year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823 Phone Area Code 517, 337-1351. ©198 Michigan State Medical Society.

LETTERS

Radial keratotomy

The following letter to the editor was prepared as a counterpoint to the MSMS president's statement on radial keratotomy appearing on page 93 of this issue.

Radial keratotomy is a relatively new procedure and thus I can only reinforce the concept that both ophthalmologists and patients proceed in a cautious manner in considering the procedure. However, I strongly feel that my colleagues and my patients should also be aware of the following facts:

1) During the last two-and-a-half years, over 3,000 cases have been performed by over 100 surgeons in the United States. Prior to this, Russian surgeons have performed the operation in over 3,000 cases during the last six years.

2) The success rate (i.e. 20/40 visual acuity without glasses or better) in my series of almost 400 cases and in other large series across the United States in 81 percent. The other 19 percent were made less myopic but not to the extent that they achieved 20/40 or better without glasses.

3) At over 20 ophthalmological meetings during the last one-and-a-half years, I have reported on any complications that anyone has seen with regard to this procedure. Although any surgical procedure can produce catastrophic complications, we have thus far not seen such complications in the performance of radial keratotomy. Furthermore, I have modified the original procedure in a manner that I think will prevent almost all of the complications I have seen.

4) Currently there are seven surgeons who have been performing radial keratotomy as a clinical investigative procedure in this state. An additional 14 ophthalmic surgeons have taken my course and are preparing to start doing the procedure.

5) Currently, radial keratotomy has been approved as a clinical investigative procedure at five Michigan hospitals and one Michigan surgery center. At least three other hospitals have agreed to accept the procedure in the near future.

6) Contrary to the attitude of the Michigan Ophthalmological Society, the Georgia Ophthalmological Society, the Florida Ophthalmological Society and the Kerato-Refractive Society, which is a national society with 1,200 members, have all designated radial keratotomy as a clinical investigative procedure . . . the same status given to lens implantation in cataract patients.

7) The only legal opinion appearing in print comes from attorney Robert M. Meals from Atlanta in the 1980 edition of *Kerato-Refraction*. He clearly states the radial keratotomy is a clinical investigative procedure and not experimental.

8) The Society of Michigan Eye Surgeons, which consists presently of only eight board members, will this month open its membership to all interested ophthalmologists in Michigan. One of our primary goals will be to offer members an opportunity to participate in a proper clinical investigative study with a strict protocol, informed consent, independent observers, and peer review, which will create a proper format for investigation and a guarantee of patient safety. Such a study will also guarantee the right of the individual ophthalmic practitioner to become involved in the investigation of *any* new ophthalmic procedure in the future.

9) Two-and-one-half years ago I made the statement that if radial keratotomy is truly an efficacious and safe procedure, two things will happen. First of all, there will be tremendous patient acceptance, and second, there will be acceptance on the part of my colleagues. The large number of referrals I have had from patients, and more importantly from many of my ophthalmic colleagues, has proven this to be the case.

William D. Myers, MD
Southfield

More on page 98

DOCTOR FRYFOGLE/*continued*

you have well-paid doctors who administrate the program, well-paid students (residents) and non-*paid* teachers (private staff doctors). The average doctor joining a medical staff gives 105 unpaid working hours over a year, plus dues and contributions."

"Yes, but" *she, the Hospital*, reminds him, "the hospital also furnishes for the doctor space, heat and light in a modern health facility — a milieu for intellectual ferment and development, use of the telephone, funding of CME activities, the medical library, research facilities, emergency room and resident coverage for your patients, plus a workshop for you to practice in."

"Hold it, both of you," says the *Marriage Counselor*. "Do you both agree that you are both trying to provide your very best skills and facilities for the health care needs of all patients?"

"I do," says she.

"I do," says he.

"Then keep *talking* and *listening* and *working together* and this marriage can be saved.

As my Scottish grandmother used to say: "Agree children — there's not so many of ye."

**Excerpts from Presidential address, Providence Hospital, January 8, 1980, Robert C. Douglass.

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/Roche) (IV), please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® Ⓘⓥ
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient
Contraindicated: Known hypersensitivity to the drug Children under 6 months of age Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy, gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy
Dosage: Individualize for maximum beneficial effect *Adults* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b i d to q i d , alcoholism, 10 mg t i d or q i d in first 24 hours, then 5 mg t i d or q i d as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t i d or q i d , adjunctively in convulsive disorders, 2 to 10 mg b i d to q i d *Geriatric or debilitated patients* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated (See Precautions) *Children* 1 to 2½ mg t i d or q i d initially, increasing as needed and tolerated (not for use under 6 months)
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

President's statement on radial keratotomy

By John R. Ylvisaker, MD, MSMS President

The procedure termed radial keratotomy has recently received widespread public attention because of its promise for relief of nearsightedness. Among ophthalmologists, the procedure has created concern, as well as some difference of opinion, regarding its use.

The Michigan Ophthalmological Society has sounded a precautionary note which calls attention to the fact that long term results of the operation are not known and that the technique may still be subject to further modification. The society has recommended that the procedure should be performed only by properly trained surgeons under the guidelines of standardized protocols, with carefully identified criteria for selection of patients and followed by careful objective review of short and long term results.

The MSMS firmly supports the scientific approach to the study of any procedure whose long-term results or effects are not yet factually demonstrated. Radial K has been recognized by the National Eye Institute as a procedure well deserving of scientific study. A national program for this purpose has been put in place.

The MSMS supports the MOS recommendation for the application of sound scientific principles of investigation in any present clinical usage of the procedure. MSMS strongly recommends that our physician members give full consideration to the large responsibility they accept in the application of this new procedure. It is also important that the public be made knowledgeable of the present status of Radial K and of its yet-to-be-determined long-term results so that any decisions to undergo this treatment will be on a fully-informed basis.

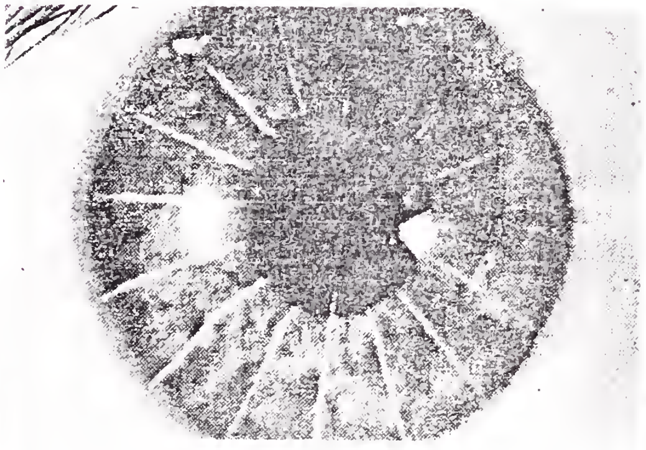


Photo courtesy Stephen A. Obstbaum, MD, New York City.
Radial slits in the eye, after radial keratotomy procedure.

Special report

Michigan physicians, hospitals share common destiny

By Judith Marr, Editor

The focus of Michigan physicians' activity seems to be moving increasingly to the hospital arena.

To function well, and to bring the best medical care possible to patients, most of today's MDs must affiliate with their local hospitals. Some physicans, such as those specializing in pathology and radiology, may provide all their services in the hospital setting, while family physicians and other private practitioners use the hospital for surgical care, medical tests, obstetrical deliveries, treatments and therapies.

This special report is dedicated to fostering the spirit of cooperation between physicians and hospital administrations, a spirit which has been growing in MSMS official actions over recent years.

MSMS and Michigan Hospital Association leaders have been meeting regularly during the past year.

In addition, MSMS Council Chairman Louis R. Zako, MD, has appointed a new Task Force to Study Relations with Hospital Chiefs of Staff, in an effort to design and recommend formal mechanisms for effective communication and working relationships between MSMS and medical staffs of Michigan hospitals.

John R. Ylvisaker, MD, MSMS president, is chairman of this task force. Members include Billy B. Baumann, MD, Pontiac; Carl A. Gagliardi, MD, Dearborn; Richard Hackley, MD, Flint; James J. Humes, Jr., MD, Detroit; Leonard H. Wolin, MD, Chelsea, and Doctor Zako.

The task force is considering an MSMS Committee for Medical Staff Relations, and seminars for chiefs of staff in management, legal, social and economic aspects of hospital staff relationships.

"MSMS is deeply committed to working with other components in the health care delivery system for better patient care at a cost we can afford," says Louis R. Zako, MD, MSMS Council chairman.

"Lines of communication and cooperative efforts with hospitals are vital to accomplish this. Thus, we've made concerted, conscious efforts in the past year or two to improve dialogue and work in a cooperative fashion in a variety of ways."

In his President's Page article elsewhere in this issue, John R. Ylvisaker, MD, MSMS president, describes his major efforts this year to "forge links" between MSMS and the Michigan Hospital Association, and between MSMS and hospital chiefs of staff.

"Because of the obvious commonality of environment and purpose," he writes, "a most important, new link has now been formally instituted with the MHA to provide leadership-to-leadership interactions on all issues of mutual concern."

The AMA, recognizing the importance of the hospital medical staff relationship in physicians' lives, offers seminars and special publications describing business, legal and leadership aspects of medical staffs.

So pervasive a setting has the hospital become for delivery of physicians' services, the Wayne County Medical Society, in a move being watched nationally, reorganized its membership plan to follow its members' hospital affiliations, as well as geographic locations.

"The society, the largest in the state with 3,500 members and one of the largest county societies in the country," wrote free-lance writer Dwight Angell in a January, *Michigan Medicine* article, "has set up a system that, in essence, parallels the changes in medicine in the last 20 years: it has become more responsive to the needs of the physicians, and it has acknowleged the importance of the hospital as the focal point for today's physicians."

Explained WCMS Executive Roger Mecum, "Physicians have become more and more affiliated with and identified with hospitals. Ten or 15 years ago physicians were very independent of their hospitals — felt no great loyalty to the institution at all. Now social and professional events are the domain of the hospitals."

Should MSMS be talking and writing about hospitals? Of course, say both Doctor Zako and Doctor Ylvisaker.

"The intimate, daily, clinical lives of practically all our members are tied up with hospital activities," emphasizes Doctor Ylvisaker.

"Major decisions are being made by physicians on medical staffs, by

hospital administrations, by MSMS and by MHA, all affecting each of these entities. It's incumbent upon us to interrelate on our common concerns and problems."

Two of the many mutual concerns Doctor Ylvisaker has been discussing with hospital administrators and chiefs of staff during his MSMS presidency are:

1) Quality assurance — "We must make sure medical records are protected so that quality assurance can continue to go forward."

2) Malpractice insurance coverage — "There is no policy set across the board on physicians' coverage in the hospital setting."

"But let's not be naive enough to assume hospital interests always will be the same as physicians'," says Doctor Zako.

There are potential roadblocks to successful mutual efforts, he points out.

1) There is the stance of many hospitals thus far, he says, to exclude MDs from their boards of trustees.

2) "Will hospitals be willing," he continues, "to consider physicians' feelings on such sensitive issues as whether physicians should be required to carry professional liability insurance to have staff privileges?"

3) "Will hospitals remain sensitive to the needs of private practicing physicians?" he continues. "Or will they increasingly place salaried physicians in key positions so that private practicing physicians on the staff have little or no input?"

The AMA House of Delegates in 1977 passed a resolution calling for physician representation on hospital boards, to assure that physicians would have a voice in hospital affairs.

The AMA policy, reaffirmed several times since, states:

"Where not legally prohibited, physicians who are members of the medical staff shall be eligible for, and should be included in, full membership on hospital governing bodies and their action committees in the same manner as are other knowledgeable and effective individuals. Other physicians also should be considered eligible for membership on the governing body. The hospital medical staff should have the right of representation at all meetings of the governing body, by medical staff members elected by the medical staff, having the right to attendance, voice and, if appropriate, vote."

In 1980, an AMA House of Delegates' reference committee also called for local efforts to change statutes which prohibit physician representation on hospital boards.

The MSMS House of Delegates has a similar position, reaffirmed in 1980. The MSMS delegates called for an MSMS survey to determine how many and which physicians are serving on Michigan hospital boards and as chiefs of staff. The Michigan Hospital Association reports that of the 170 hospitals for which they have data, 92 have physicians on their boards. Those boards average two physician trustees.

Good working relationships can be established in the hospital setting.

It is to that goal that this special section, and its writers' efforts, are dedicated. And it is to good working relationships between physicians and hospitals that MSMS liaison and study also are directed.

"I'd rather be negotiating than be an ostrich," says Doctor Zako, in summation.

"Physicians and hospitals have common destinies," says Doctor Ylvisaker. "It is essential for us to carry on a dialogue."

We can change confrontation to cooperation

By William J. Downer, Jr., Grand Rapids

The next several years in Michigan have the potential for creating new and increasingly disruptive conflict between physicians and hospitals. Our ailing economy, increasing external pressure for health care cost containment by government and business, as well as the continued almost insatiable demand by individual patients and physicians for the latest in technology will lead to new tensions. Physicians, hospital trustees and hospital directors will be challenged as never before to work together to solve these problems in the best interests of society as a whole.

We've already begun to see the effects of the Michigan recession in our hospitals. Initially we experienced increased demand for services. To a large degree, the demand continues. We have seen more and more of our patients who, having exhausted their unemployment benefits, enter a "never-never land" where they must "spend down" their assets before qualifying for Medicaid assistance. During this period when they need and receive medical services they tend to become long-term accounts receivables for both physicians and hospitals. Superimposed upon this is the continued increase in the complexity of services physicians and patients expect our hospitals to provide.

Mr. Downer is president, Blodgett Memorial Medical Center, and chairman, Michigan Hospital Association Board of Trustees.

Hospitals have always been a major focal point for the delivery of medical care services. They are also increasingly costly, given the need for 24-hour services and increased service intensity while less costly medical services are handled on an outpatient basis.

Hospitals must maintain the delicate balance of resources required for their long-term fiscal liability. This is absolutely essential if the hospital is to continue to provide needed services to its community. This thrust of hospital management, usually expressed through the hospital's budgetary process, may, with increasing frequency, create conflict with individual physicians and the organized hospital medical staff over the provision of expanded and better staffed services and new technology.

Fiscal responsibility

The physician always must be concerned about the needs of his or her individual patient. Hospital management, on the other hand, is forced to look at the collective needs of all the patients and make recommendations for the most prudent use of increasingly scarce resources to the hospital's board of trustees. For it is the board of trustees which ultimately is responsible for everything that takes place in the hospital.

Few physicians, trustees or hospital directors are equipped through training and experience to deal easily with the economic realities of the 80's. We remember well the governmental pronouncements of the 60's and early 70's. Health care was mandated as a "right" for all Americans. A dual or multi-track delivery system, based on the need or ability to pay for services, was not a consideration. Despite the warnings of knowledgeable health professionals, politicians made too many promises and underfunded public programs. Medicaid may be the classic example of this kind of program. But, increasingly, we see Medicare and Blue Cross following a similar pattern. Expanded benefits are mandated but monies to pay providers of service are a secondary concern.

Additionally, the health field is singled out regularly for stringent regulation on the premise that competitive forces do not work well in our field. A good example is certificate of need (CON) legislation. It takes a minimum of six months from approval by the hospital board of trustees of a project requiring a CON before final state approval can be obtained. This is a source of great frustration to physicians and hospital management.

Common problems

It is encouraging to see in many of our hospitals that organized medical staffs, boards of trustees and hospital directors are realizing that we have much in common in dealing with our problems. This recognition is leading to a major turning point in medical staff-hospital relationships. From the joint conference committee in the individual hospital, to the newly formed liaison committee between leadership of the Michigan State Medical Society and the Michigan Hospital Association, we need to concentrate on identifying our problems, areas of agreement and areas of difference. We then need to develop cooperative, unified positions wherever possible, keeping in mind our ultimate commitment to effective use of those resources our society allocates for health.

I think both doctors and hospitals must support the movement toward greater physician involvement in hospital operations, through membership on hospital governing bodies and their operating committees. This will better insure physician participation in the overall problem of resource allocation within the hospital. Simultaneously it may be wise to appoint a trustee to several medical staff committees for the same reasons.

The next few years do have the potential for physician-hospital confrontation. But it is within our power to change this to cooperation — if we will.

Beleaguered or not, MDs, hospitals must cooperate

By Kenneth L. Urwiller, MD, Pontiac

The physician-hospital administration working relationship has not always been totally compatible. But the common goal has always been to provide quality care.

Today, both physicians and hospitals face unprecedented needs for communication and cooperation. The issues which concern both are numerous. But their unity has been strengthened and enhanced as they respond to common adversaries.

MDs, hospitals face problems

Physicians and hospital administrators contend with many pressures daily.

The physician is constantly reminded of government regulatory bodies such as the IRS, HHS and FTC. Then there are voluminous amounts of paper work from medical records and insurance forms; required hospital, staff and committee meetings, and worst of all, the constant threat of malpractice suits, apprehension inherent with peer review, and on and on.

The hospital administrator must face daily pressures in dealing with third party payors, government and other regulatory bodies, budget controls, debedding, fund raising, expanding hospital facilities as well as maintaining hospital buildings and equipment, labor relations and service to the community. Finally, these problems must be explained to the governing board in a meaningful manner, with reasonable solutions suggested.

Yet, while we may be beleaguered, we must respond to the challenge positively, constructively and imaginatively. There is so much to be gained by cooperation.

Most people believe changes leading to this unstable era in medicine began in the 1950's when this country was formulating its civil rights philosophy. The doctrines relating to health insisted on "equal access to health care for all Americans." Following that, Medicare-Medicaid legislation was enacted, as well as many other health care social benefits. As these programs mushroomed, the country became aware that all Americans still did not have access to health care. We responded with legislation and regulations that extended far beyond health care providers to almost everything related to health care today. By the 1970's, these changes in health care were costing large sums of money. Then we began the present cost-containment era.

Now it seems there is a greater need than ever for physicians and hospital management to work together and coordinate their efforts.

Conflicts between the two may arise. Physicians want the setting for their patients to be warm, congenial, quiet, clean, have good appearance and be efficient. They want a well-managed hospital, with all employees well-schooled and sensitive to patient problems. They want the hospital to provide the maximum in diagnostic and therapeutic capabilities. They want to have pride in their institution and its place in the health care system.

The hospital administration wants to provide all of this. However, there is always a question of resource allocation. The hospital administration must respond constructively, remembering such problems as cost-containment, cost-effectiveness, regional planning and quality control. The administration must answer for the cost of operation to the governing body, the community and the Federal Government.

There may be some conflict then, between what physicians want and what the hospital administration can provide.

Communication and cooperation are mandatory for a healthy physician-administration relationship. It is vital to have physicians serve on hospital governing bodies — to directly communicate their philosophy, role and concern for quality patient care. This position is difficult, as the physician must constantly remember he or she is serving not only as a physician advocate, but as part of the entire hospital operation.

Further, it is important for physicians to serve on board committees and subcommittees to provide information to nonphysician board members of internal hospital problems and the role of the medical staff to solve such problems.

The governing bodies must provide seminars to acquaint physicians not only with hospital problems and functions, but with medical staff functions. Finally, it is most important to choose members for the governing body who are knowledgeable of hospital problems and who recognize the hospital's primary purpose is to serve the health care needs of the community.

What MSMS can do

What then can MSMS do? MSMS must encourage the principle of physician appointments to the hospital governing body.

Further, MSMS must make every attempt possible to influence our legislators to repeal, or at least modify, some legislation enacted in the last 20 years which has created so much of the burden and expense for both physicians and the hospital.

Finally, MSMS must work closely with the Michigan Hospital Association. For together, we can accomplish much more.

Doctor Urwiller is president, Oakland County Medical Society, and former president of the medical staff, St. Joseph Mercy Hospital, Pontiac.

Mandatory CME

A proposed resolution asking MSMS to work with the state legislature to amend the Public Health Code to delete mandatory continuing medical education was supported by the Oakland County delegates and alternates by the (overwhelming?) vote of 8 to 7.

Broader support is desired. Why? 1984 is soon to be upon us. By 1984, according to present law, the Michigan Board of Medicine must implement further procedures to assure competence. Recertification is one mechanism under consideration.

Mandated CME in Michigan is expensive; costs continue to rise. Mandated CME has not influenced the incidence of malpractice suits, one of its initial goals. These suits continue to increase in frequency. The expense to the state for verification of submitted hours in attendance of accredited courses is unknown, but it must be substantial. Michigan can ill afford unnecessary expenses in this recessionary era. Efforts to constrain errant physicians continue to require discovery and due process, whether or not mandated hours have been submitted, verified, recorded and stored. Medical advances continue despite mandated CME, not because of it. Many courses incorporate review rather than exploring new avenues of medical care in order to qualify for Category I credit.

Nationally, Michigan ranks in a small minority of states which, having a CME law and operational requirement, still fail to recognize the AMA's Physician Recognition Award, the well known PRA. It is one of eight states in this category. (*JAMA* 244:2835,80).

This same article suggests that the trend toward mandatory CME on a national basis has halted.

We must at this time, with MSMS support, convince the legislature to void the CME requirement and to void references to competence certification. Competence is a quality which cannot be quantitated or subjected to some universally-acceptable standard of measure.

If we fail to make our views known, MSMS will fail to act. If MSMS fails to act, we shall witness competence assurance measures in due course. Mandated CME will not serve as a deterrent to recertification in my view, as things now stand. A fresh look needs to be taken, now, at the failure known as mandated CME and this entire subject of state intervention into the practice of medicine.

There is a national hope for decreasing needless and useless regulation. Such hope should permeate the state. A good place to start would be to amend the Public Health Code to delete references to mandated CME and competence. The public is being deluded into believing that the present law has brought commensurate returns. I say to those in power who think so, show us the evidence. I think there will be none.

It would be hoped that full, fair and open discussion of this matter may be aired at the coming MSMS house of delegates meeting. Members should contact their delegates to make their views known well before the meeting in May. Only a well-informed delegate can vote his conscience . . . you must be the one to inform him of your views, on this and other matters of importance to you. If we sit back to watch what transpires, we will not take the leadership role which is required to participate in shaping our own destiny. Of course, the choice is yours.

Richard A. Wetzel, MD
Birmingham

P.S. The views are those of the author and not necessarily those of the Oakland County Delegates and Alternates who supported or who opposed the resolution noted above.

Doctor Siegel

The following letter was sent recently to David Siegel, MD, Lansing, who resigned in December from his post of chairman of the MSMS Medicaid Liaison Committee.

As a member of the Michigan State Medical Society who has benefited from your fine work in the Medicaid liaison committee I want to say thank you for your efforts. I also recognize your unique ability to verbalize the physicians point of view to the Medicaid people. Often you obtain for physicians what I thought might be impossible and although I do not know of all your work I know that it was not an easy task and that you sacrificed much in doing it for the physicians of Michigan.

Walter L. Howland, MD
Bay City

Editor's note: Here is a quote from the bottom of Doctor Howland's stationery which is worth sharing: "Good health cannot be bequeathed by another nor guaranteed by a government but, like happiness, must be pursued by each of us for ourselves."

Bob Hope

Thanks so much for sending us a copy of the December *Michigan Medicine*.

Enjoyed Willah Weddon's story on our boss — and thought she did a fine job of researching.

Would it be possible to obtain two additional copies of the magazine? Would like to include it in Bob's current scrapbook — and of course, one for the planned museum.

Last and far from least in importance — her quotes! Thank you, Willah, wherever you are.

Norma Brown
Bob Hope's office
N. Hollywood, CA

DES Action

DES Action/Michigan recently acquired a 15-minute slide/tape presentation for health workers. Trained DES Action volunteers are available to give in-service training workshops on how nurses and other health care providers can alert DES-exposed mothers, daughters, and sons. The show describes the facts of DES, questions to ask patients, how to tag files, following up suspicious cases, tracing medical histories, and counseling exposed patients.

Contact DES Action/Michigan at P.O. Box 66, East Lansing, 48823, or phone (517) 371-2223.

Sincerely,

Judith Baker
DES Action/Michigan
Lansing

25 YEARS

Experience Managing Group Insurance Programs

Disability Income Protection, Life Insurance Coverage, Business Overhead Insurance, Special Accident Insurance...

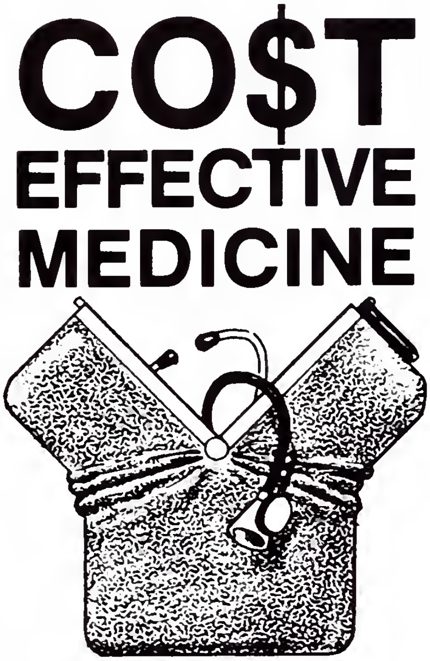
For the past quarter century Stratton-Cheeseman and Associates has been serving Michigan State Medical Society members, saving you money and offering the kind of high quality, competitive products necessary to meet your insurance needs. Contact us for further information about disability income protection, life insurance, business overhead disability coverage, special accident insurance. . . for all your insurance needs, for you and for your employees. Call toll free 800/292-1966.

Stratton-Cheeseman & Associates, Inc.

P.O. Box 1563, 1305 Abbott Road East Lansing, Michigan 48823
Phone: 517/351-5780

MSMS wants MDs' ideas for cost-effective medical care

By R. Jack Chase, MD, Grand Rapids



Doctor, do you practice out of this bag? The Task Force on Medical Care Costs hopes that you always use this bag.

The Task Force on Medical Care Costs was established over two years ago, and you may recall, published five Practical Guidelines: 1) "Cost Awareness, Diagnostic Testing," 2) "Pre-Admission Testing," 3) "Discharge Planning," 4) "Outpatient Surgery Program," 5) "Cost Savings in Surgery."

While I am sure that most of you read these practical guidelines, I ask you, have you reread them? Do these Practical Guidelines still effect your day-to-day practice of medicine? I would guess not, yet I would hope they still do.

Your Task Force also had joint meetings with representatives of the Michigan Hospital Association and prepared a booklet, "Physician's Guide to Selected Patient Charges and Hospital Reimbursement." This booklet was designed to allow hospitals to show their individual charges and is available for their use. Additionally we have met with representatives of the medical schools to discuss teaching cost awareness to med students.

The Task Force and I have sensed that there are problems in "selling" cost-effective ideas to physicians, not the first of which is characteristic physician independence. Many doctors feel they should do anything and everything that needs to be done regardless of cost. Some physicians say they must do everything they can to avoid malpractice claims. Still others say, "It is covered by insurance or the government" when you and I know it is really paid for by all of us. Other physicians tell us that cost-effective medicine doesn't apply to them or that they have already heard too much about it.

Indeed there is some truth in all of these points, but we still must be dedicated to cost-effective medical care. Such care must be in our medical bag. But what is the best method of delivering a constant stream of ideas on cost-effective medical care to you, the practicing physician in the mainstream of medicine?

At regional and national meetings, members of MSMS staff and I have noted a seeming preoccupation for the establishment of a data base of impressive statistics which really apply mostly to hospital medicine and are expensive to compile and in and of themselves, don't save a penny.

Another very important point in the delivery of the idea of cost-effective medicine is that this term means something very different to various physicians. A hospital pathologist, radiologist, or hospital administrator will tell you that decreasing the number of procedures or procedure costs decreases income while costs stay the same. Hospital administrators note the same apprehension when we talk about shortening hospital stay and decreasing bed occupancy with a resultant decrease in income. Likewise, a shorter hospital stay has no effect on the income of a physician who charges a unit charge, but a direct effect on a physician charging a per diem charge. And of course, cost-effective medicine has a totally different meaning to different specialties. Imagine this difference, for example, between pathologists and psychiatrists, radiologists and internists, family practitioner and dermatologist, or surgeon and pediatrician.

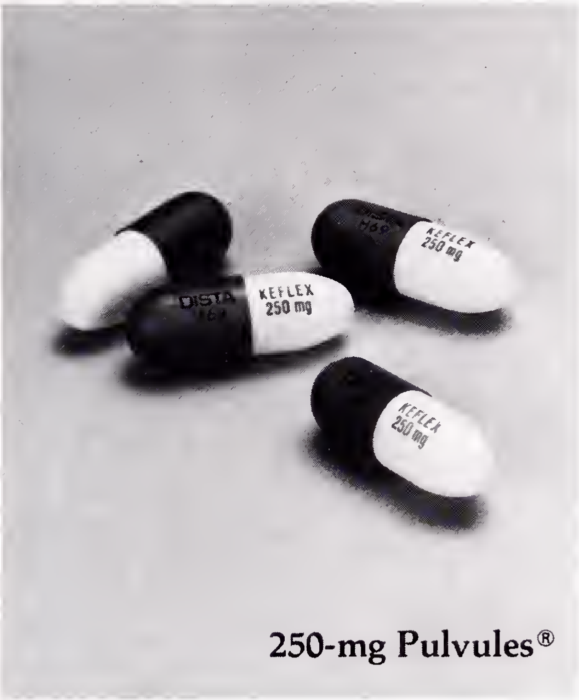
How then can we best provide an ongoing program on cost effective medical care? We would like to enlist your help. Physicians do listen to other physicians. We would like to publish in nearly every issue of *Michigan Medicine* and "Medigram" a well written article by one of you doctors that gives us your thoughts and ideas on cost-effective medical care. Tell us what it means to you, *from your specialty, from your area, from behind your desk.*

You can help us reach more doctors more effectively. If you are interested in cost-effective medical care, please send us your article in care of John Richards, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, 48823.

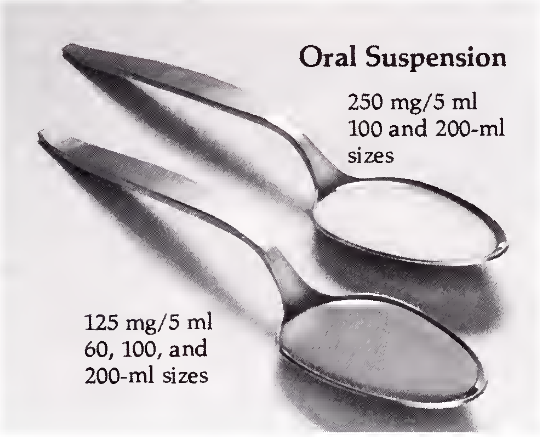
Proposed articles should be typewritten, double-spaced, with one extra copy included. Task force members will review the articles and would like the writers to include their specialties. All contributors will be gratefully acknowledged, and those the task force feels are most valuable will be published.

Doctor Chase is chairman, MSMS Task Force on Medical Care Costs.

easy to take



250-mg Pulvules®



Oral Suspension
250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes

Pediatric Drops
100 mg/ml
10-ml size

Keflex®
cephalexin

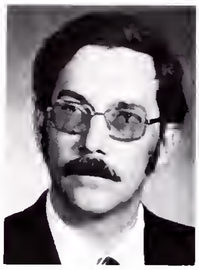
Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Limits of PSROs' success determined by physicians' leadership

By Daniel J. Fall, MD, Ann Arbor



The following article is excerpted from a report delivered at the 1980 MSMS Public Affairs/Leadership Conference in Lansing. It provides an excellent prospective look at the possibilities of the PSRO structure in Michigan.

In all likelihood, PSROs will continue to be controversial for the forseeable future. Vague or unrealistic expectations, inaccurate measurement strategies and political dynamics will enable Congressional committees to argue the merits of the program for some time to come.

However, as PSROs mature, they will become increasingly able to document their impact and value. As such data become available, the argument about PSROs will shift from a question of their existence to a debate of their relative worth (when compared against competing priorities).

As the landscape of health care politics changes, issues relating to the use and quality of health care will become increasingly important. This is especially true in light of the limitations being placed on health care budgets. If physicians are to retain and enhance the many prerogatives granted to them by the PSRO law, support for local efforts must be continually increased and diversified.

The following areas of activity represent a sampling of issues and opportunities which require serious consideration by the medical profession and PSROs alike:

A. **Health planning.** The decisions of local Health Systems Agencies (HSAs) can have a significant impact on medical practice through regional resource allocation. PSROs have specific legal prerogatives which permit them to review HSA plans and provide medical comment. Although these prerogatives have not been used substantially to date, local PSRO initiatives are beginning in this area.

B. **Private review.** The business sector and the insurance industry are approaching various PSROs for professional review contracts. The private sector is attempting to take advantage of existing programs of medical peer review in order to assure that their monies are properly spent. Thus, not only have PSROs created a linkage with government, they have provided a framework which is attractive to business. A possible outcome of these private activities is a unique partnership between business and the medical profession — the payors and the providers of health care.

C. **Medical education.** The education of physicians might be enhanced by PSRO data and study findings. Formal liaison with medical schools and residency programs could create a greater awareness of cost-effectiveness and efficiency in medical care. Current and future practice patterns might be favorably influenced by such educational programs.

D. **Technology assessment.** As health care technology increases in scope and complexity, concerns are raised regarding its relative costs and benefits. The government has created a National Center for Health Care Technology and a National Center for Health Services Research to provide funding in these areas. PSRO involvement in such efforts could afford practicing physicians an opportunity for direct input and influence in important research activities. Studies and projects designed by practitioners could conceivably provide benefits to the health care community, regulatory agencies and the public.

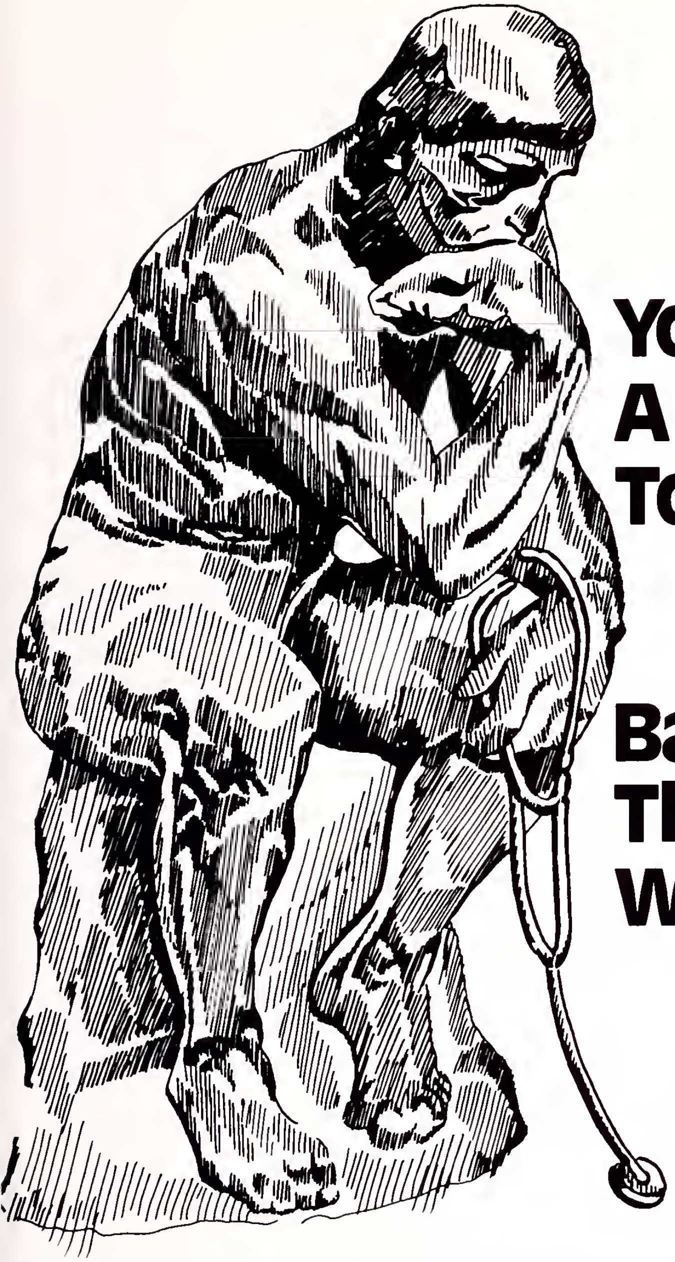
In the light of the long-standing controversy and distortion surrounding the PSRO program, it is no surprise that most physicians are either indifferent or skeptical about PSROs, physician control notwithstanding. Further, other more pressing concerns affecting the medical profession have absorbed most of the energy that might otherwise have been spent on any objective analysis. However, as the decade of the '80s begins, PSRO-related issues have moved from the fringes to the forefront of health care debate.

To the extent that PSROs are flexible and imaginative, they can become as dynamic as medicine itself. PSROs can serve and promote professional activities in a manner consistent with local consensus. They have the unique potential of becoming a new forum for a wide range of areawide initiatives. Private sector status and a regional perspective can serve to remove bias and enhance credibility. However, substantial and diverse physician support is indispensable to insure success.

It would also seem reasonable to suggest that PSROs might forestall or prevent actual government regulation of medicine that might otherwise be developed in their absence. Short of this extreme possibility, (but no less significant) PSROs can assure that physicians retain important means of input into policy making processes.

Although the preceding does not address all of the relevant issues that affect PSROs, it seems reasonable to conclude that the limits of PSRO options and success will ultimately be determined by physician leadership and resolve.

Doctor Fall is president of the Michigan Statewide Professional Standards Review Council.



You Give A Lot Of Thought To Your Decisions...

Base Your Thoughts On Facts With CRT Systems.

In order to know whether you're making the decisions that will keep your practice operating efficiently, you need factual, understandable information about your accounts receivable activities. But you can't afford to spend your time involved in non-medical matters. That's why you need a computerized management system that provides you with concise, in-depth information about your practice's profitability while freeing you and your staff from non-productive paperwork and accounting functions.

Here's how CRT's Medical Billing and Information System Works.
For a modest monthly charge, CRT will install an easy-to-use terminal in your office. Your transactions are analyzed in various ways to generate insurance forms, claims, reports, billings, statements, service and payment analyses, transaction journals . . . all the information you need to evaluate and control your business and accurately document all services, charges and payments. And it keeps staff costs down by eliminating redundant work such as typing claims, insurance forms, receipts, day sheets, statements, etc. Start making the right decisions now. **Contact CRT Management Company • 6934 West Fort Street • Detroit, MI 48209 • (313) 554-2330**

CRT
MANAGEMENT
COMPANY

☐ Please send me CRT's Information System Brochure.

☐ Please call me to arrange a no-obligation demonstration of CRT's Information System.

NAME ______________________

ADDRESS ______________________

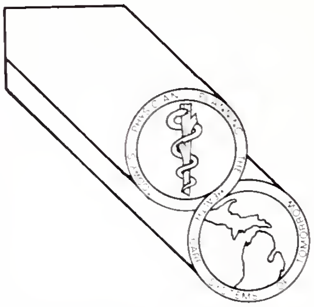
____

PHONE ______________________

Mail to: **CRT Management Company • 6934 West Fort Street • Detroit, MI 48209 • (313) 554-2330**

HEALTH PLANNING UPDATE

By Dennis Paradis, Director
MSMS HSA Support Center



Appropriateness Review

The Office of Health and Medical Affairs has issued a proposal to amend the Appropriateness Review (AR) Work Program. The amendment would extend the State's review responsibility from six months to one year after the HSAs have completed their review. Another amendment calls for a three-month extension of the date which HSAs are required to begin AR for Medical/Surgical Hospital Services (now 1-1-82) and Pediatric Hospital Services (now 4-1-82). Reasons for the delays include time to assess the position of the Reagan administration on AR, an attempt not to overburden the HSAs, which have to complete both bed reduction plans and HSAs in 1982, and time for the State to move into a new, and hopefully stronger, fiscal year.

State of the State

Health planning figured prominently in Governor Milliken's State of the State Message, which was delivered in January. Citing concern over the cost of health care, the Governor asked for legislative support for the bill to create the Hospital Capacity Reduction Corporation. In another section, the Governor called for continuation of the Excess Hospital Bed Reduction Program, although he added a comment that there must be sensitivity to varying needs in the different parts of Michigan. Other gubernatorial proposals in the health planning field include a task force to examine rate setting alternatives for hospitals, the possibility of establishing a graduate medical education planning system, the creation of a Michigan health services corps to alleviate physician maldistribution, and a feasibility study for a capital expenditure limitation program for hospitals.

Long term care

The Michigan Association of Health Systems Agencies has undertaken the challenge of developing a statewide long-term care methodology. The organizational meeting was held in early March. The undertaking of this study is consistent with the position of the MSMS Council which reviewed the issue in December and sent a letter to the Michigan Department of Public Health urging that such a study be conducted as soon as possible.

HSA plans

With their enabling legislation running out in 1982, HSAs are thinking about short-term strategies to complete an impressive track record to present to Congress. In a letter from Colin Rorrie, Director of the Bureau of Health Planning of DHHS, the HSAs were urged to concentrate on a limited number of top priority programs that will show results. The letter indicated that the emphasis should be on results rather than process.

The same communication indicated that HSAs should base their budget projections on 40.1 cents per capita, a 22 percent reduction from the previous year, and federal matching funds of 67 cents per local dollar, a 23 percent reduction from last year. Since the time the letter was written, the Reagan administration has proposed a new budget, which may further reduce funding to the HSAs.

Support your Michigan Medicine advertisers

"Quality" United States & Canadian Decimals Since 1958

CARLTON
NUMISMATICS, INC.

- Professional Numismatic Counseling •
- Acquisition of Rare Coins •
- Portfolio Management •
- Investment Programs •

via
I.R.A., Keogh & Pension and Profit Sharing
Retirement Plans

To receive your complimentary copy
of our Current Price List and
Descriptive Brochures,
please write or telephone:

Bingham Center • Suite 1646
30700 Telegraph Road
Birmingham, Michigan 48010
313 / 646-8846

BUSINESS HOURS: Wednesday - Saturday 10:00 A.M. to 3:00 P.M. and by appointment.

Life Members A.N.A, C.N.A., M.S.N.S.: Associate Members C.A.N.D.

Maternal Health Desk Reference Card No. 25

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society)

STANDARDS FOR NUTRITIONAL CARE[1]

Nutritional support services within maternal and infant care should be developed in communities.

Antepartum patients and caretakers of newborn infants should demonstrate knowledge and understanding of basic nutrition facts necessary for health promotion.

If weight reduction is indicated because of pre-pregnancy obesity or excessive weight gain during pregnancy, a reduction regime should not be started until after breast feeding is completed.

All antepartum patients should have nutritional evaluation.

> Height should be measured, without shoes, at the first prenatal visit and recorded to the nearest one-fourth inch (0.5 centimeter). Weight should be recorded at each antepartum and postpartum visit and recorded to the nearest one-fourth pound (0.1 kilogram).
>
> Caloric intake should be sufficient to support a consistent, steady weight gain averaging 22 to 27 pounds (10 to 12 kilograms) during the course of pregnancy.
>
> Dietary assessment will be made throughout pregnancy or as indicated.

All patients with a disease which affects fetal growth or maternal nutritional status should receive nutrition assessment and appropriate intervention.

All diabetic patients should have continuous dietary monitoring and counseling.

Women using IUD's or oral contraceptives should have nutritional evaluation and education prior to any attempt to conceive.

All infants, including low birth weight infants, should receive phytylmenaquinone (vitamin K), 0.5 to 1 mg, I.M., immediately after birth.

Infants born after uncomplicated pregnancy and delivery who are in no distress should be fed according to a protocol designed to provide an adequate nutritional intake. Breast milk is the milk of choice.

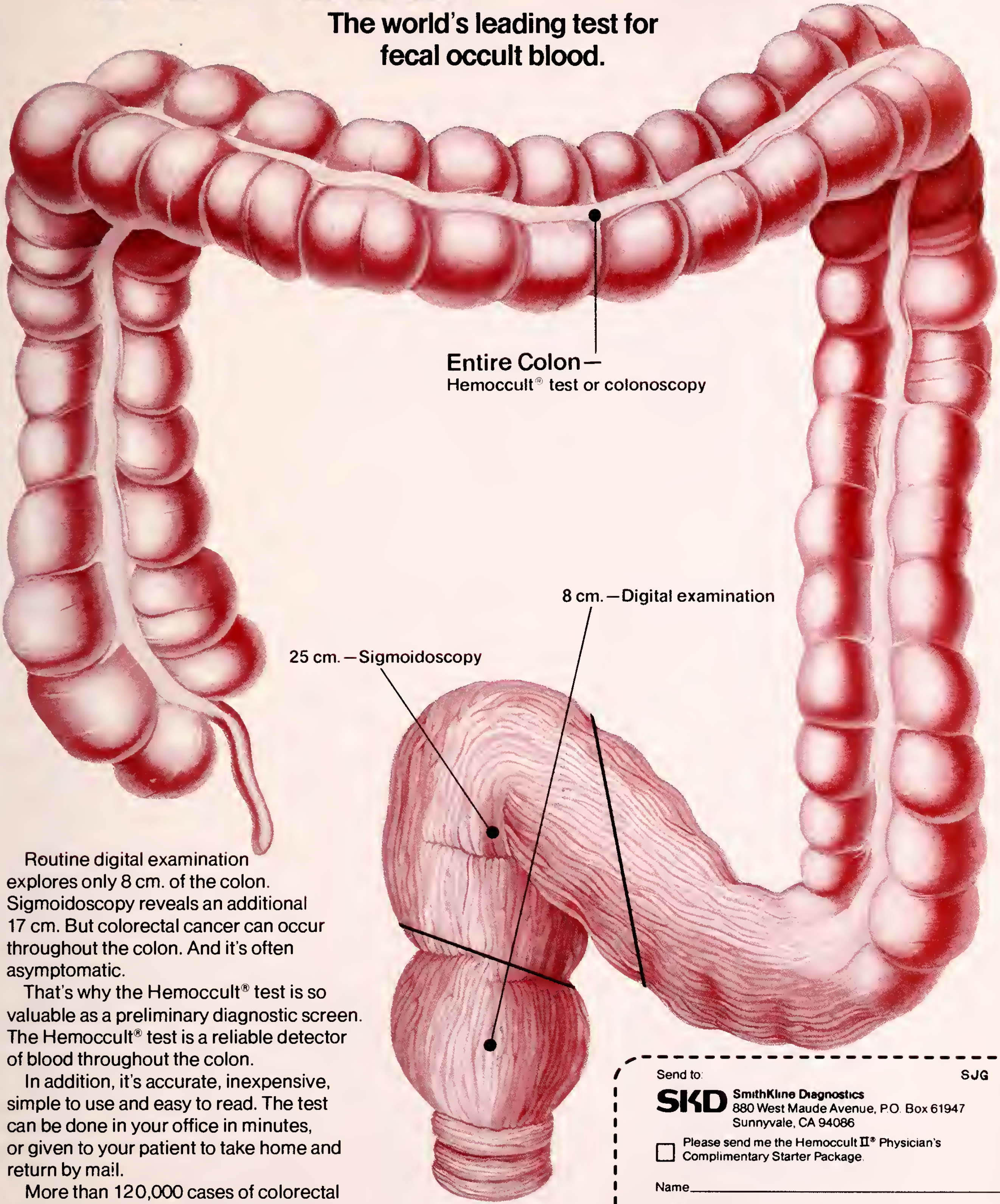
Mothers who wish to breastfeed should be encouraged to do so. Hospital routines and rules should be modified to promote successful breastfeeding.

A referral system for continued follow-up should be established by the health facility to appropriate local providers.

Taken from MDPH H-804 1979, "Suggested Guidelines and Standards for Maternal and Perinatal Nutritional Care." Copies can be obtained from the Michigan Department of Public Health, Box 30035, Lansing, 48909.

Hemoccult®

The world's leading test for
fecal occult blood.



Routine digital examination explores only 8 cm. of the colon. Sigmoidoscopy reveals an additional 17 cm. But colorectal cancer can occur throughout the colon. And it's often asymptomatic.

That's why the Hemoccult® test is so valuable as a preliminary diagnostic screen. The Hemoccult® test is a reliable detector of blood throughout the colon.

In addition, it's accurate, inexpensive, simple to use and easy to read. The test can be done in your office in minutes, or given to your patient to take home and return by mail.

More than 120,000 cases of colorectal cancer will occur in the United States this year. The earlier they are diagnosed, the greater the chances for successful treatment. Send for your free Hemoccult® starter package, today.

Hemoccult® is available through local distributors, nationwide.

Send to: SJG

SKD **SmithKline Diagnostics**
880 West Maude Avenue, P.O. Box 61947
Sunnyvale, CA 94086

☐ Please send me the Hemoccult II® Physician's Complimentary Starter Package.

Name____________________

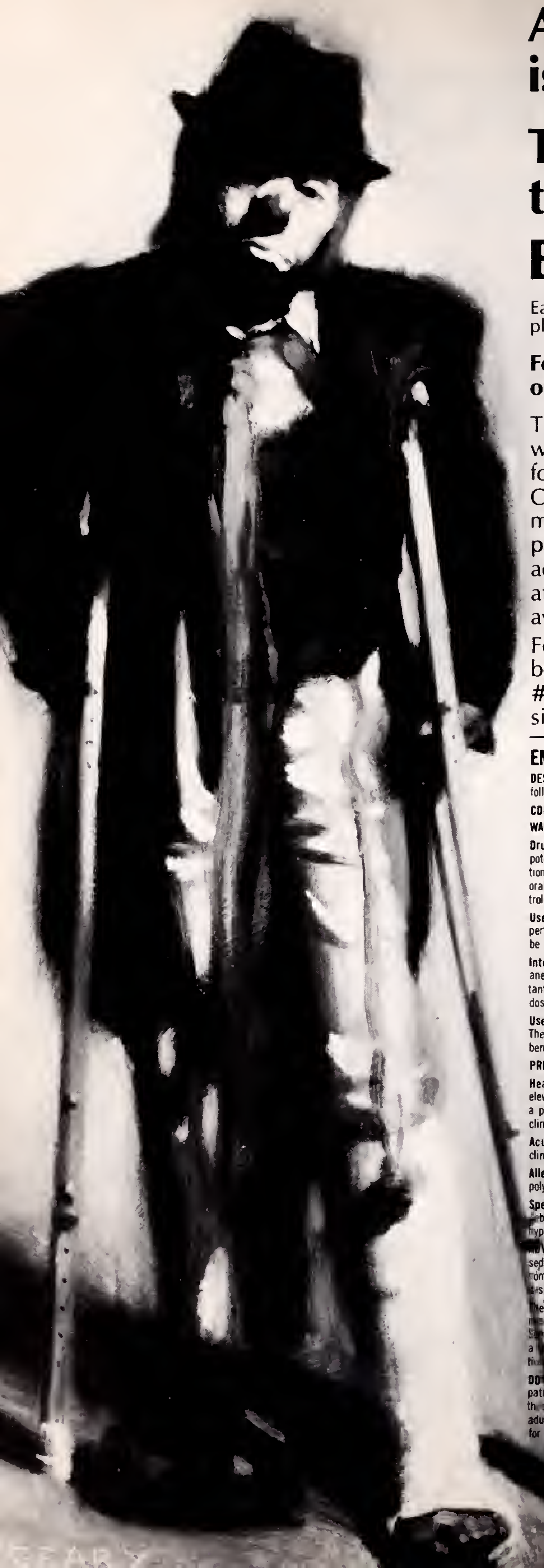
Medical Specialty____________________

Address____________________

City__________ State________ Zip________

Phone____________________

© SmithKline Diagnostics, 1981 HM: 100A-1280



Acute pain is no laughing matter.

The first prescription for the first days of acute pain

Empirin® c̄ Codeine #3

Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming).

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin c̄ Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin c̄ Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with . . . two tablets of Empirin c̄ Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming.)

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Ambulatory surgery continues to prove itself

By Paul T. Lahti, MD, Royal Oak

In 1968 I reported the results of a program of early post-operative discharge. Since that time the concept of ambulatory surgery has developed and is being adopted throughout the country. This is a report of the first five years of experience of the ambulatory surgery center at William Beaumont Hospital in Royal Oak.

The details

William Beaumont Hospital serves a metropolitan area of approximately 430,000, with a bed capacity at its main unit of 940.

Since the opening in 1975 of the Surgery Center for ambulatory surgical patients 26,899 operative cases have been done. This represents 24.4 percent of all surgical procedures at William Beaumont Hospital.

This does not include the "lumps and bumps" which are done under local anesthetic in a separate "clinic surgery" room. These cases totalled an additional 9,195 cases.

The types of surgery performed in our ambulatory center run the gamut, and include gynecological; ear, nose and throat; general; pediatric; orthopedic; ophthalmologic; plastic; urologic; proctologic; thoracic; cardiovascular, neurological, and oral.

One hundred eighty-eight, or less than one percent, of the patients operated in the ambulatory unit were admitted to the hospital. The main reasons for admission were: incomplete recovery from anesthesia, post-operative bleeding, and finding of malignancy.

They also included post-operative nausea and vomiting, observation, post-operative pain, perforation of uterus, post-operative hematoma, post-operative hypotension, post-operative dizziness and faintness, atrial fibrillation and cardiac arrhythmia.

Doctor Lahti is a general surgeon and former MSMS Councilor.

In our general surgery practice, adult hernia patients are screened pre-operatively to evaluate their reaction to the concept of ambulatory surgery. Each patient is offered the choice of in-patient or out-patient.

It is obvious from the reaction of the patient during the discussion as to whether he will want the out-patient setting. If there is any hesitation of the part of the patient, the in-patient setting is recommended with the understanding that the patient will be able to go home the day of surgery, in most cases.

Sixty percent of our adult inguinal hernias are done in the ambulatory center.

Breast tumors for which the clinical impression is benign are done in the ambulatory center. If there is a strong suspicion that the tumor is malignant, the patient is done as an in-patient.

When a malignancy is found in the ambulatory unit, the patient is admitted to the hospital. The options for further surgery are discussed with the patient and the family, and the further surgery is done the next day. Patients in general accept surgery for breast tumors done is this manner since they know they will have their breast when they awaken.

It is our feeling that some patients seek help sooner because of this arrangement.

Patients with hypertension or other disabling conditions are done on an in-patient basis.

Acceptance excellent

Patient acceptance of the ambulatory surgery center has been excellent. The results of a patient attitude survey conducted at William Beaumont Hospital showed a high level of patient satisfaction overall, in that 99 percent of the 461 respondents rated the out-patient surgery services as excellent or good.

All patients are given written instructions for post-operative care, and a pamphlet with directions and general information regarding ambulatory surgery. They are warned not to drive a car the day of surgery. The next day, patients are allowed to drive and to carry on any activity they wish.

We request all of our patients to shower as soon as they get home. This relieves any spasm or discomfort and most patients do not require narcotics post-operatively. Daily showers also keep the wound clean. They are discharged without a dressing unless there is drainage, in which case a small dressing is applied over the drain and the patient is advised to wash over the drain and the incision.

All patients receive a phone call from the office the next day to check on their condition and to answer any questions.

The only death came after 24,851 patients had been done. This was a 27-year-old white female who had a dilation and currettage for recurrent vaginal bleeding. The patient was well, awake and talking within a few minutes of the completion of the D and C when she suddenly said she "didn't feel well," then complained of a severe headache, vomited and became unresponsive. All efforts to resuscitate failed. No cause of death was found at autopsy.

Cost saving

We estimate the cost saving of our ambulatory surgery approach to be approximately $5 million per year in hospital days not used and in extensive laboratory and x-ray studies usually ordered on in-patients which we do not do.

HEW reports that in 1975 approximately 20 million surgical procedures were done in the United States. We believe at least 25 percent of all these procedures could be performed in an out-patient setting, giving a net savings to the nation of $5 billion dollars.

In addition to the actual immediate saving, there is a tremendous saving in disability payments and in man-hours lost to the economy.

The ambulatory setting is proven safe, it is cost effective, it is beneficial to the patient's well being and it considerably reduces the patient's period of disability.

In January
4,631
Michigan
physicians
were very happy
because of us.

Here's why:

Rates

Effective January 1, 1981, the Michigan Physicians Mutual Liability Company (MPMLC) reduced its rates for the **third** time in **three** years. Sixteen of the eighteen basic class and territory rates were reduced. The overall reduction averaged **9.7%** for MPMLC's 3500 insured physicians.

For example, a Territory 1 anesthesiologist **saved $925** for $200/600 coverage. In Territory 2, an ob/gyn surgeon **saved $1888** for $200/600 coverage.

1980 Dividend

The Board of Directors of MPMLC, all fellow Michigan physicians, declared a 5% dividend to 1980 policyholders. As a mutual company, MPMLC is able to pay a dividend to its policyholders who own the company. The dividend is **in addition to** the above rate decrease.

Interest Payment

MPMLC paid interest of 7% per annum to 4,631 physicians and physician groups who purchased Surplus Certificates in past years. The purchase of a Surplus Certificate is **no longer required** for insurance.

If you weren't one of the physicians who saved money or received a dividend from MPMLC, maybe it's time you looked into the exceptional insurance coverages we provide.

MPMLC is Michigan's 2nd largest provider of professional liability insurance for physicians and 25th largest in the United States. It is run by physicians. . .for physicians. MPMLC is your company.

Michigan Physicians
Mutual Liability Company

P.O. Box 1471
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926 toll free

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

After-hours pediatric clinic alternative to emergency service

By Sally A. M. Steinborn, special to Michigan Medicine

Doctor Comstock and after-hours clinic nurse Chris Card, RN, check in Ulysses, left, and Andrew Neyland, Lansing.

Children have never been able to confine their illnesses to the regular office hours of their pediatrician. So to make life a little easier on both the physician and the patient, Lansing-area doctors have developed the Pediatric After-Hours Clinic.

The special emergency service, managed by the Pediatric Physician Corporation of Lansing, is headed by Howard C. Comstock, MD. It works in conjunction with the Lansing-area Michigan State University-affiliated Graduate Medical Education Corporation, under the pediatric residency program, directed by George Baker, MD.

"One of the original reasons it was formed," says Doctor Comstock, "was to offer ambulatory experience for the resident pediatricians. They are required to work in the emergency room during their residency."

The clinic allows the residents to work side-by-side with an experienced pediatrician, he says.

Doctor Comstock, originally from Monroe, has presided over the clinic since it opened in 1974. The University of Michigan graduate opened his practice in Lansing in 1954.

Doctor Comstock said every pediatrician in private practice in the Lansing area is involved with the clinic. The 20 doctors work on a rotating basis, which averages about two nights a month.

The clinic services an estimated 7,000 patients yearly, on a walk-in basis.

The original charter was, "don't turn anyone away," Doctor Comstock explains. Most of the time the clinic is able to adhere to that rule. Only on a few occasions was the waiting room so crowded that only the patients involved with the private practice physicians were admitted.

The expansion of St. Lawrence Hospital allotted the space needed for the clinic. It has four sick rooms, four isolation rooms, and one emergency treatment room.

Rather than a regular service fee, the physicians are paid an hourly wage. Doctor Comstock explained that the system offers each doctor a modest pension and a profit-sharing plan. There is a group insurance policy as well, he said.

There is an executive group of officers who have periodic meetings to discuss the treatments received at the clinic. "Through staggered elections, each doctor holds a two year term in office," he says.

A good by-product of the meetings is the type of peer review available for the doctors. Records are kept on each patient treated by the doctor who provides treatment.

This enables the physicians to keep an eye on each other as well as stay on top of new techniques, Doctor Comstock explains.

The hospital also supplies a nurse to help the doctors. They work on a rotating basis, and are paid through the hospital.

One evening, Head Nurse Chris Card was able to take a few minutes off to discuss the clinic.

"We needed a pediatric approach to emergency cases," she said. "It really is not necessary to subject children to the gore of the emergency room."

Nurse Card, who has been working at the clinic since 1975, said they usually see an average of 15 children nightly. "The most we have ever served in one night was 54," she added.

Like any other pediatric office, the waiting room has a full supply of toys and magazines to keep waiting toddlers busy.

The clinic is open from 6 to 10:30 p.m. Monday through Friday, and from 3 to 8:30 p.m. weekends and holidays.

There are two other such clinics in Michigan. The Lansing Pediatric Physician Corporation based its system on the original clinic in Flint. Since that time, Ann Arbor has opened a similar service. Doctor Comstock has received phone calls from pediatricians in other areas of the country expressing interest in the clinic.

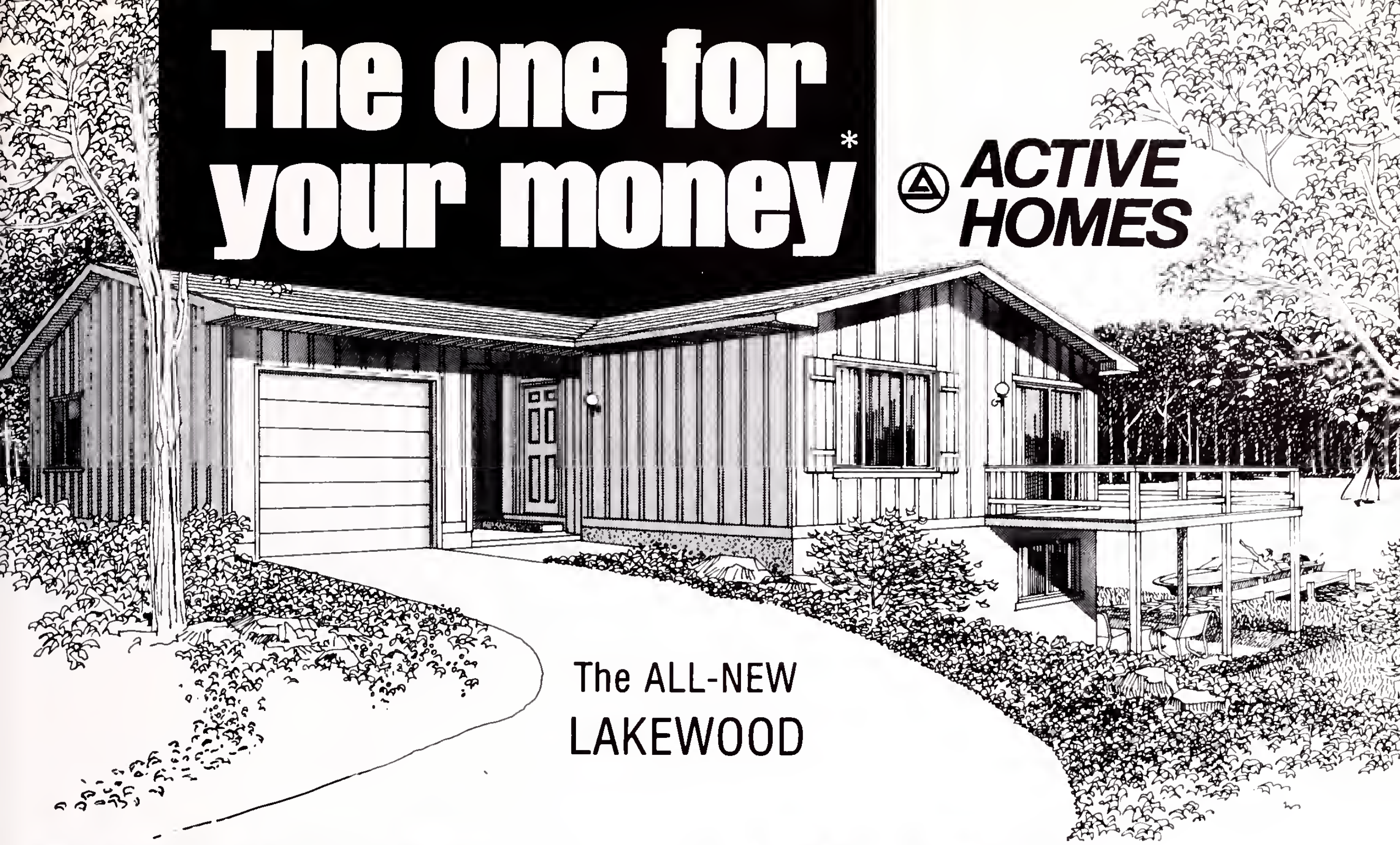
He would recommend this type of service for other hospitals.

"We are able to meet a legitimate need for patient care," Doctor Comstock said, "as well as take some of the burden off the emergency room."

"I think this clinic is a good thing for the town."

The one for your money*

ACTIVE HOMES

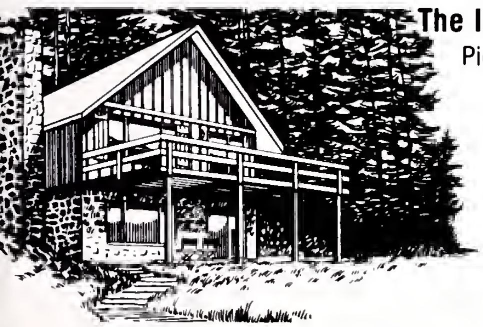


The ALL-NEW

LAKEWOOD

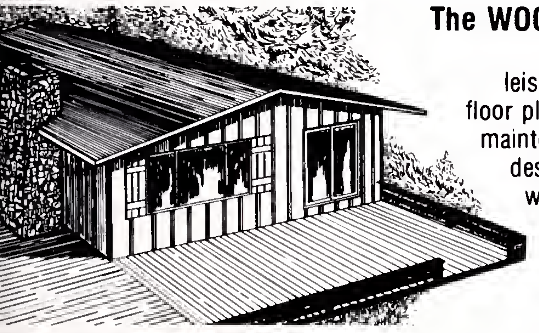
Affordable Leisure Retreat

Whether you want it for pleasure or for profit . . . on the shore or in the woods, the Lakewood is tops for value and appreciation in today's leisure living market.



The INTERLOCHEN

Picturesque leisure home with up to 1536 sq. ft.; several floor plans; many features and options. Room, beauty, livability . . . *right price*!



The WOODHAVEN

Real buy in leisure homes; floor plan options; maintenance-free design; priced within nearly everyone's range.

Economical Fulltime Home

Compact, yet spacious. A 2 bedroom house that can expand to 4. A beautiful kitchen, ceramic bath and a host of luxury features make The Lakewood ideal as a starter home, a versatile vacation retreat, a house with a future.

Start Building Equity NOW! . . .

Don't just build a house; make an investment. Our vacation homes provide a unique opportunity. You save big with our low prices. You get a quality house to enhance your lifestyle and your pocketbook. And you have the rental option open to you. It all adds up to a wise move.

BETTER GET ACTIVE

I'm interested in a
☐ Lakewood
☐ Interlochen
☐ Woodhaven

ACTIVE HOMES

NAME:
ADDRESS:
CITY/STATE/ZIP:
PHONE:
I have land in ______________________ County.
☐ I'm also interested in multi-family investment opportunities.

MM-381

ACTIVE HOMES CORPORATION

PO Box 127 • Marlette, MI 48453 • (517) 635-3532

* Even MORE for your money with special discount – ASK ABOUT IT NOW!

Meet James D. Fryfogle, MD: the next MSMS president

By Shelton Reece, special to Michigan Medicine

Dr J
Fryfogl

MSMS President-elect James D. Fryfogle, MD is one of those rare individuals who always seems to be in a hurry but who somehow manages to give his undivided attention to the person, or situation, concerning him at any given moment.

He says he became a surgeon because he was in a hurry — in a hurry to help patients get well — to remove whatever caused their illness and start them back on the road to good health.

Born in Ontario, Doctor Fryfogle's accomplishments witness the fact that he was moved through life at a rapid pace. He grew up in Detroit, attended Albion College on an athletic scholarship and earned a Bachelor of Arts degree there in 1939. His MD was obtained in 1943 at Wayne State University College of Medicine. He also holds a MS degree in surgery from the University of Minnesota which was awarded in 1947.

He completed his internship at Providence Hospital in 1944 and continued graduate training in surgery at the Mayo Clinic from 1944 until 1948. He was licensed to practice medicine in Michigan and California in 1943 and was accepted as an American Board of Surgery member in 1950.

A noted thoracic-cardiovascular surgeon, Doctor Fryfogle is a member of the staff at Mt. Carmel Mercy Hospital, Detroit, and at Providence Hospital where he was chief of staff in 1979. He also is the founder and a director of the W. D. Fryfogle Medical Research Laboratory which was named for his father.

Active in medical society and health planning groups, he was a Wayne County Medical Society Council member from 1952 until 1975; on the board of trustees, 1970-1975; and president of the society in 1970. With MSMS, he was a delegate, 1952-1980; on the Council, 1970-1980; vice speaker of the House of Delegates, 1970-1976; and speaker, 1976 to 1980. He was president of the Michigan Chapter, American College of Chest Physicians in 1964, and was a member of the Michigan Medical Service (Blue Shield) Board of Directors from 1962 until 1968.

Doctor Fryfogle has been active in the federal health planning arena since the beginning of that activity. He was on the executive committee, Area-Wide Health Operating Council from 1969 to 1971. From 1971 until 1978, he served on the Comprehensive Health Planning Council as a member of the executive committee, board of trustees, as vice president, and finally as president. In 1978-1979, he was a member of the Health Systems Agency's board of trustees and served on its Executive Committee. Additionally, he has been chairman of the Seven-County Health Planning physicians advisory committee since 1978.

Among the many professional organizations, other than MSMS and WCMS, of which Doctor Fryfogle is a member are: American Medical Association, Society of Thoracic Surgeons, Michigan Thoracic Society, American College of Chest Physicians, American Heart Association, Detroit Heart Club, Michigan Cancer Foundation, Detroit Surgical Society, and the Detroit Academy of Surgery.

One of his major concerns is the influence that government and third-party payments have had on the delivery of medical care.

"Perhaps the main reason that I agreed to be president of MSMS is that I want to organize a doctor-sponsored conservation of health dollars. I plan to use the office to promote real efforts towards effective control of health care expenses," Doctor Fryfogle states.

"Today, many physicians know nothing but government and third-party pay and the requirements that system of payment exerts on the way they practice medicine.

"I don't plan to propose anything really revolutionary, but I do hope to help re-establish what I consider to be the heart of medicine; the doctor-patient relationship.

"I know and trust my MSMS colleagues, and I feel that they know and trust me, so I think we will have a good working relationship during the coming year.

"Those problems that are government-initiated, we will handle. Those problems that are initiated by organizations other than government, we will handle. And those problems that are our own, we will work on."

Despite his hurried professional schedule, Doctor Fryfogle still finds time for sports. He played football, basketball and golf at Albion, and currently plays tennis and golf in tournaments. Another of his hobbies is singing. He has been a member of various barbershop quartets for the past 35 years. Now he is a bass with the Oakland County Wolverine Chorus and with a quartet comprised of physicians known as The Borborygmi.

A devoted family man, Doctor Fryfogle met his wife when they were grade school students. Of Mrs. Fryfogle he comments, "She was an English major at the University of Michigan, an extremely fine editor, and she has done an excellent job of editing our lives ever since I was lucky enough to persuade her to marry me." The couple has three grown, married children: Randall, Anne, and Laurie. They also have five grandchildren.

Doctor Fryfogle consults with surgical nurses.

He joins hospital staff members in encouraging surgical patient.

There is time for light-hearted fun in his busy schedule.

Baffin Island medical experience includes polar bears, caribou hunt, Eskimos

By Orville Oughtred, MD, Mt. Clemens

Doctor Oughtred with a catch of Arctic char.

I spent the month of August at the Frobisher Bay General Hospital, at Frobisher Bay, Baffin Island.

About the middle of the month, a rescue plane brought in an Eskimo from the settlement of Pangnirtung who had been clawed and mauled by a polar bear. The back of his scalp had five large claw marks down to the skull, through the galea, and continued down to the back of the neck. He was bled out to seven and a half grams.

Three hours later I had him put together using two grams of Keflin every eight hours for infection, and three units of blood for rescusitation.

The next morning on ward rounds, I encountered him in the hall, smiling happily and pushing his intravenous pole. He was back home in seven days with instructions to the nurse practitioners at the nursing station for suture removal and dressings.

My patient told me he was 59 years old. When he found out I was about the same age, he said we were brothers. He was busy planning another hunting trip when he left the hospital.

Northwest Territories

This was one of my memorable experiences while serving at Frobisher Bay General Hospital, one of two federal hospitals in the Northwest Territories. The hospital has 55 beds and is administered by the Federal Department of National Health and Welfare. (My official employer was the Canadian Northwest Territories Region Medical Services branch of the federal department.)

Frobisher Bay General Hospital has full accreditation, as attested by the framed certificate in the entrance hall. This base hospital provides medical, dental, and public health services for the Eastern Arctic.

There are nine geographical regions in Canada providing health services for Canada's native people. Each region is headed by a regional director, and staffed by doctors, nurses, and other health personnel and administrative staff.

The regions are divided into zones and field units. Zone directors report to their respective regional directors. The branch operates hospitals, nursing stations, and public health units situated throughout the country.

The east-west distance between nursing stations is approximately 700 miles, north and south approximately 1,000 miles. The 12 nursing stations in the Eastern Arctic are at Arctic Bay, Broughton Island, Cape Dorset, Clyde River, Grisefiord, Hall Beach, Igloolik, Lake Harbour, Nanisivik,

Pangnirtung Fiord

Pangnirtung, Pond Inlet, and Resolute Bay.

Nurses are employed in all health facilities.

Each station is staffed with one or two nurses trained beyond usual requirements, who are able to provide special treatment in midwifery and public health service. The settlements served by these 12 nursing stations vary in size from 80 to almost 1,000 persons.

Physicians are able to make only periodic visits to nursing stations. Nurses by necessity rely on radio-television communication for medical advice and assume responsibilities beyond normal requirements in Canada. Clinical training of nurses for their added responsibilities is available at many Canadian universities.

During my stay at Frobisher Bay Hospital, there were two nurse practitioners completing a tour of internship and furthering their practical knowledge before transfer to their next assignment at a nursing station.

The Medical Services Branch personnel carry out quarantine and regulatory programs to set out requirements to insure healthy living standards.

Public service health also is incorporated in the Medical Services Branch. It is intended to augment, not compete with, public and private medicine. Both the private and public sector are expected to extend comprehensive occupational health coverage to public servants; counseling, health education, and referral are provided for troubled employees.

Community health training programs also are carried out by the Medical Services Branch. These involve the Inuit people in health activities. Native people are encouraged to enter nursing and medical professional ranks.

Frobisher Bay

The pressing problem at Frobisher Bay is venereal disease. Native community health representatives are selected for specialized areas in health education. These committees are elected or appointed in the settlements and are indoctrinated into playing an active role in delivery of health care in these immediate communities.

The western side of Baffin Island is flat. This area is called the Melville Peninsula. The Eastern side where Frobisher Bay is located has spectacular mountain peaks and fiords. Frobisher Bay is treeless, rocky, and barren with rolling hills and mountains to the far side of the settlement. The number of people in Baffin Zone is approximately 7,500, with 2,600 being located at Frobisher Bay, including 1,800 Inuit and 800 non-natives.

The Twin "Otter," a medium-sized twin engine, is used for local runs, and 737 jet provides service and freight between Montreal, Frobisher Bay, Hall Beach, Nanisivik and Resolute Bay.

Frobisher Bay General Hospital is staffed by three general practitioners and one general surgeon, 11 registered nurses, eight nursing assistants, and a number of clerk interpreters.

The hospital and settlements are provided with dental services by three dentists at Frobisher Bay. The public health program is provided by four public health nurses, and two community health representatives.

Maternal and child health, accident prevention, immunization and TB prevention programs are carried out.

Approximately 160 persons make up the health team in the Baffin Zone. There is a McGill Frobisher program using residents at the Montreal General and Montreal Children's Hospital for patients admitted from the Eastern Arctic to these hospitals. Two social workers assist in making arrangements for patients when they are in Montreal.

Consultants in subspecialties visit Frobisher Bay each month. When I was in Frobisher Bay we had a radiologist from Ottawa, a cardiologist, and an orthopedic surgeon from Montreal. Usually residents in pediatraics, family practice, or internal medicine rotate each month through Frobisher Bay General Hospital, including a medical student for one or two months. These appointments are eagerly sought.

Frobisher Bay was established by the United States government when an air strip was built in 1943. The air base was taken over by Canada at the end of the war.

One of my confreres in Mt. Clemens recollects that a medical officer was sent to Frobisher Bay during the interval. When he returned to London he required three months of psychiatric rehabilitation.

The Strategic Air Command in the late 1950's and 1960's used Frobisher as a base for refueling B52 bombers. The airport is modern and is used for refueling many overseas flights.

Pangnirtung

Pangnirtung, one of the closest nursing stations to Frobisher Bay, has received considerable publicity in the Canadian Geographic Magazine. It is termed the gateway to the only Arctic park, called Auyuittug National Park, pronounced (Ay you ee took). Pangnirtung Pass is the main entrance to the 8,300-square-mile national park. It is a deep valley with glaciers adjoining Pangnirtung and connecting Cumberland Sound and Davis Strait.

Several hundred visitors yearly may visit the entrance, which I did. Less than a tenth hike the full 60 miles from Pangnirtung Fiord adjoining Cumberland Sound to the North Pangnirtung Fiord adjoining Davis Strait.

I have very little enthusiasm for this hiking area of the high Arctic. One of the nurse practitioners from Pangnirtung lost her life while attempting to hike through the pass. Her funeral took place on the day I visited Pangnirtung.

During my stay at Pangnirtung, I spent $75 for one night's lodging and meals at the local lodge. This was a bargain if you considered the alternative. I took a trip up the fiord to the entrance of Auyuittug National Park. The fare was $50. I bought two Eskimo prints made at Cape Dorset from the Eskimo Co-op for $400. The air fare from Frobisher to Pangnirtung was approximately $180.

During the month of August, one of the staff doctors made the trip through Pangnirtung Pass during his vacation. He spoke of his experience as a mixture of ecstasy, soul-searching, hardship, hunger, and frightening encounters with potential falls and unpredictable weather. While at Pangnirtung, I visited the local nursing station which ordinarily carries a complement of three nurse practitioners. Sunday afternoon I returned to Frobisher and the air strip fence was serving as a stretching area for seal skins and caribou hides.

Caribou Hunt in Baffin Island

During my final tour of duty, I had a long weekend. I joined a charter flight for a caribou hunt to Amadjuak Lake in mid-Baffin northwest of Frobisher Bay. Robert Gledhill, MD, the orthopedic surgeon, and Paul Stubbings, MD, resident family practitioner, and 10 or 12 Eskimos arranged the flight.

The lake is full of Arctic char. One of the Eskimos shot a caribou at 525 yards from our tent encampment. The tents were set on gravel. There isn't a stick of wood to be seen, only arctic moss.

The Eskimos were as joyful as I was miserable. I wouldn't have missed it. Don't ask me why.

My two doctor friends looked after me as though I were their father. The Eskimos called me the big doctor; a kind remark about by obvious overweight. Eskimos respect older people, they wouldn't say anything to hurt your feelings. Besides they knew I had sewed one of them up with about 60 or 80 sutures.

I was in a new world and enjoyed every moment. The kindness and respect these people gave me were part of the experience.

The miserable nights at camp at Lake Amadjuak made me feel much more akin to the Eskimo prints I bought at Pangnirtung. I dreamed about them in my halfsleep; every sound I heard I thought of a prowling polar bear. It was delightful to see the number of super high powered rifles and ammunition my Eskimo friends had. We could have held off the German Army.

Back in Frobisher the temperature was in the mid 50's. One day it was 60 degrees fahrenheit. There were complaints that it was too hot. During the winter, 35 to 40 degrees below zero is usual. Daylight varies from 24 hours in June, to five hours in mid December.

Returning to Frobisher Bay, I realized time was running out and I would be leaving. I spent $500 on Eskimo carvings which, in three days on returning home, I had given away to grasping offspring.

I attended the Anglican Church services and felt a little closer to the infinite. This church building is shaped like an igloo. It is the seat of the Bishop of the Arctic and is called St. Jude's Cathedral. There are no cushioned kneeling areas; prayers are a little uncomfortable.

Departure from Frobisher

It was the end of August. In a short time I had made close friends. The chief of the hospital and his family came down to the air strip to see me off. I had in a short time become attached and part of the place.

I knew this would happen. I had been north before. You can't escape the hold the Canadian Arctic can exert if you allow yourself to be exposed to its mysterious environment.

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN

Healthy Competition Makes A Healthier Market

Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.

Occurrence Coverage

Choice of limits— $100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

family practitioners

Seeking a board certified/eligible family practitioner to join family practitioner and general internist in a high quality growing practice in northcentral rural Wisconsin. Modern clinic building adjoined to community hospital. Call shared with two other physicians in a nearby community. Associate membership, then membership affiliation with a large multispecialty medical group 60 miles distant offering the full spectrum of consulting services and providing laboratory and administrative support and continuing medical education opportunities. Salary and fringe benefits excellent. Practice experience desirable but not mandatory. This is an excellent opportunity to exercise your talents in adult medicine, pediatrics, and OB-GYN in a small community environment practicing with skilled colleagues while enjoying a reasonable call schedule, freedom from business administration, and the security of ready access to consulting specialists in all fields. Send curriculum vitae and the names of persons who can be contacted for reference to:

FREDERIC WESBROOK, M.D.
Marshfield Clinic
1000 North Oak
Marshfield, WI 54449

MEDICO-LEGAL

Here's a case for record books

The following is an interesting account of a complicated Oakland County medical malpractice case pending since 1976. This account was forwarded to *Michigan Medicine* by MSMS Legal Counsel A. Stewart Kerr.

Randy Grodin, a minor, together with his father and mother. Dennis and Roberta Grodin, brought an action against Roberta Grodin's obstetrician/gynecologist. They alleged that as a result of the doctor's failure to diagnose pregnancy, Roberta Grodin took Tetracycline while pregnant with Randy, causing his teeth to grow in brown.

After taking the doctor's testimony at deposition, Randy and his father joined Roberta Grodin as a co-defendant, alleging that she was negligent for failing to seek proper pre-natal care, for failing to request the doctor to perform a pregnancy test and for failing to inform him that she was taking Tetracycline as prescribed by another physician.

Roberta Grodin (as defendant) brought a motion for summary judgment prior to trial claiming parental immunity and that Randy and his father could not continue alleging obviously inconsistent facts against Mrs. Grodin and her doctor. The trial court granted the motion for summary judgment prior to trial claiming that Mrs. Grodin was immune from civil suit in this case on the grounds of parental immunity because the alleged negligent acts involved an exercise of reasonable parental discretion with respect to the provision of food, clothing, housing, medical and dental services and other care.

Randy and his father appealed and the Court of Appeals reversed, holding that there was a question of fact which had to be determined at trial as to whether or not the exercise of parental discretion was "reasonable." As of this writing, it is unknown whether Mrs. Grodin as defendant plans to seek leave to appeal with the Michigan Supreme Court. If the decision stands, it will effectively abolish the doctrine of parental immunity.

Trial of the case should be interesting. Which side of the table should Mrs. Grodin sit at? Randy Grodin and his father are in an embarrassing situation: siding with mother's version in her action against the doctor but siding with her doctor's version in their action against her. If things will be confusing in the courtroom, what are they like at home?

These Michigan cases are detailed by AMA in Citation newsletter

"*Wife Cannot Sue For Malpractice on Husband*," District Court of Michigan, March 28, 1980, from the *Citation*, Vol. 41, No. 12.

"*E.R. Physician Not Negligent In Death of 4-Year-Old Boy*," Michigan Court of Appeals, March 18, 1980, from the *Citation*, Vol. 42. No. 1.

"*Patient Sues Manufacturer For Injuries From Lincocin*," Michigan District Court, March 27, 1980, from the *Citation*, Vol. 42, No. 1

"*Patient and His Wife Awarded Damages For Swine Flu Shot Injuries*," District Court of Michigan, June 23, 1980, from the *Citation*, Vol. 42, No. 4.

"*No Government Immunity For Michigan Hospital*," Michigan Supreme Court, June 30, 1980, from the *Citation*, Vol. 42, No. 4

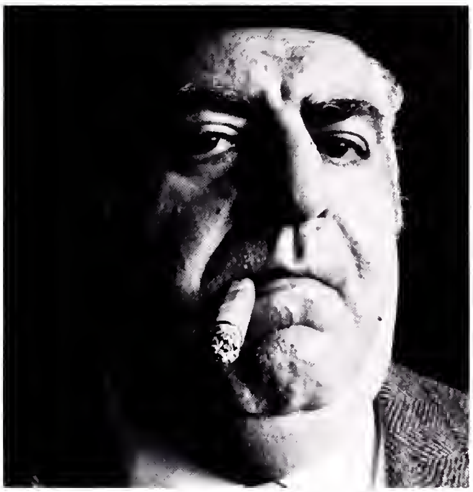
"*Podiatrist's License Revoked By Board*," Michigan Court of Appeals, May 5, 1980, from the *Citation*, Vol. 42, No. 5.

"*Unsuccessful Vasectomy Case Not Barred By Time Limits*," Michigan Court of Appeals, April 21, 1980, from the *Citation*, Vol. 42, No. 5.

"*Governmental Immunity Applied to 1975 Suit*," Michigan Court of Appeals, April 22, 1980, from the *Citation*, Vol. 42, No. 5.

"*Charges Against MD Dropped Due To Entrapment Defense*," Michigan Court of Appeals, March 18, 1980, from the *Citation*, Vol. 42, No. 5.

THE ART OF OWING MONEY...



"PAY THE DOCTOR/DENTIST LAST."

Consumer magazines are advising people with financial problems to pay their doctors and dentists last...if at all. But now you have help - I.C. Systems - an effective and ethical system for collecting delinquent accounts. A nationwide collection service, I.C. is approved by your association. Mail this coupon today to learn more...

The System Works IC

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ______________________________

Address ____________________________

City _______________________________

State ______________________ Zip __________

Signature

Michigan Board of Medicine disciplinary actions

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized:

- **Larry L. Kompus, MD**

Jackson State Prison
3000 Cooper
Jackson, 49201

Date, action taken
Sept. 23, 1980
Revoked effective
Aug. 6, 1980

Violation
A departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.

Incompetence.

Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes.

- **Primitivo P. Rivera, MD**

945 Wemans Street
Hamtramck, MI 48312

Date, action taken
September 23, 1980
Reclassification of
Limited License
Denied effective
August 6, 1980

Violation
Petitioned the Board for reclassification of his Limited License dated November 21, 1979.

- **Paul L. Gradolph, MD**

23338 Woodward Avenue
Ferndale, 48220

Date, Action Taken
November 12, 1980
Probation extended from 11-12-80 to 11-12-81

Violation
Failed to comply with terms of probation as set forth in the Board's final order dated 11-1-79.

- **Michael P. Grant, MD**

110 Vine
St. Charles, 48655

Date, Action Taken
October 1, 1980
Reprimand and Limited Medical
License from 10-11-80 to 4-11-81
and Probation from
4-11-81 to 10-11-81

Violation
Obtaining, possessing, or attempting to obtain or possess a controlled substance as defined in section 7104 without lawful authority; or selling, prescribing, giving away, or administering drugs for other then lawful diagnostic or therapeutic purposes.

Failure to use reasonable care and discrimination in the administration of drugs, and failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease.

Selling, prescribing, giving away, or administering drugs for other than legal or legitimate therapeutic purposes.

A departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.

A violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals whether or not injury results, or any conduct, practice, or condition which impairs, or may impair, the ability to safely and skillfully practice the health profession.

Incompetence.

- **Mary Herlihy, MD**

110 Vine Street
St. Charles, 48655

Date, Action Taken
October 1, 1980
Reprimand and Request to maintain a controlled substance log for a period of 6 months

Violation
A violation of general duty, consisting o failure to exercise due care.

Incompetence.

Prescribed drugs for other than a lawful diagnostic and therapeutic purpose.

- **Richard A. Jankowiak, MD**

3165 Treadwell
Wayne, 48184

Date, Action Taken
October 1, 1980
Dismissed without prejudice as he did no
attempt to renew his temporary license

Violation
Sold a drug for other than a lawful diagnostic or therapeutic purpose.

- **Donald R. Krohn, MD**

27600 Farmington Rd. #102
Farmington Hills, 48018

Date, Action Taken
February 7, 1979
Reprimand and Suspension from
7-9-80 to 8-8-80
Probation from
9-8-80 to 9-8-83

Violation
Being guilty of immoral conduct.

- **Judith C. Lieberman, MD**

U of M Health Services
207 Fletcher
Ann Arbor, 48108

Date, Action Taken
November 5, 1980
Limited License during Probation from
11-5-80 to 11-5-82

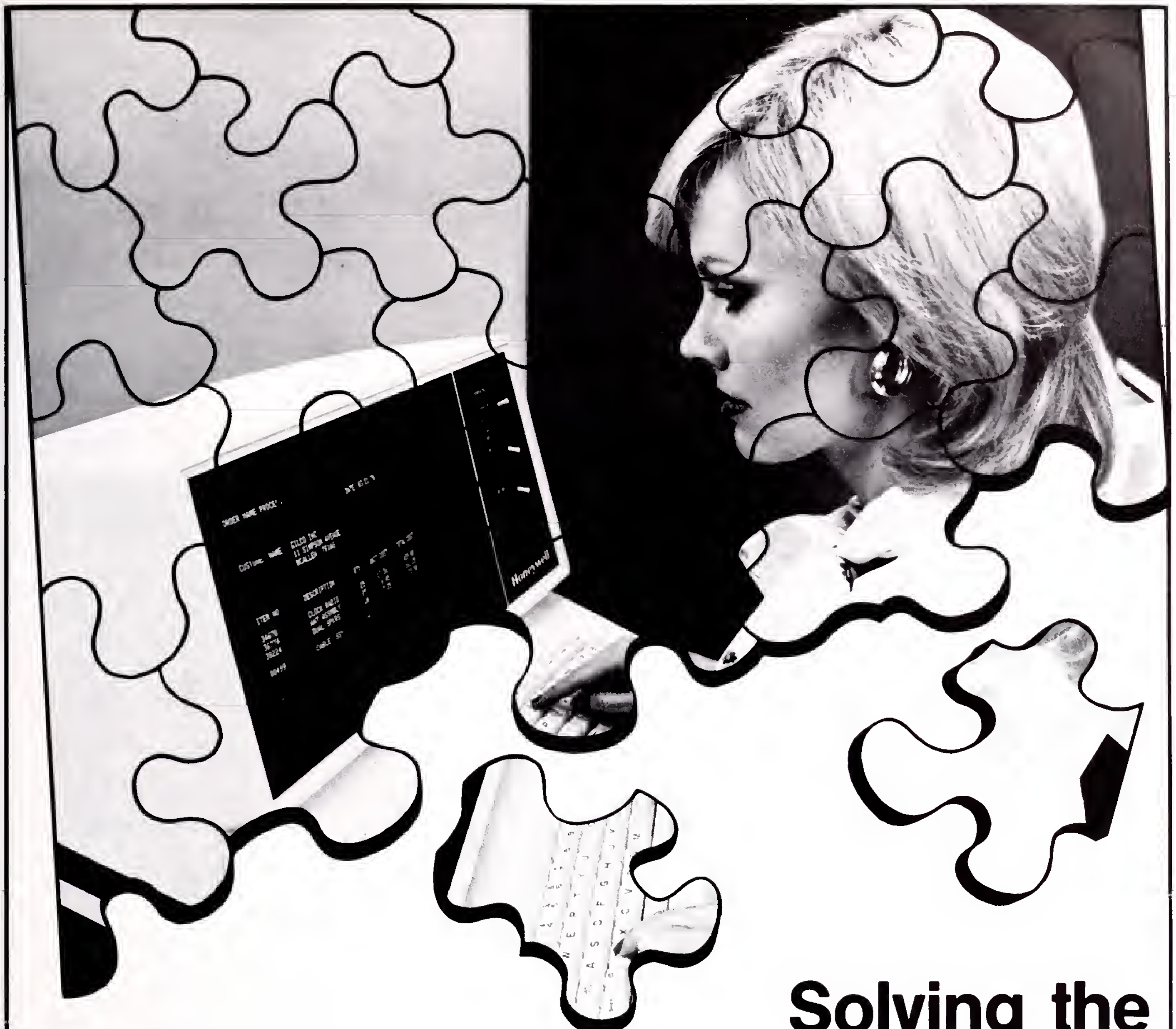
Violation
Unlawfully obtained, possessed or attempted to obtain or possess a controlled substance, and prescribed a drug for other than a lawful diagnostic or therapeutic purpose.

- **Charles O'Shaughnessey, MD**

15 E. Kirby, Apt. #1231
Detroit, 48202

Date, Action Taken
October 1, 1980
Probation from
10-11-80 to 10-11-82

continued on page 124



Solving the Computer Puzzle

Purchasing an office computer system can be a time consuming and confusing process. Particularly when it comes to putting together all the "pieces" necessary for a smooth, trouble-free installation.

The Paradata/Honeywell Medical Computer System provides the modern medical office with an economical and productive means of "taking care of the paperwork" by offering the following components:

Hardware: The Honeywell Level 6 is a full function business computer designed to offer the most advanced electronic technology and growth capability available today.

Programming: Years of design and local field testing have been combined to provide a program package tailored to the specific needs of the Michigan doctor.

Training: Knowledgeable representatives will work with your operator until the fundamentals of efficient operations have been mastered.

Service and Maintenance: In-house service is provided by Paradata customer engineers. A periodic maintenance agreement is also available.

In short, our system is complete, installed, and offers all the "pieces" from a single source. It's the system engineered by professionals for professionals.

ParaData
OF MICHIGAN, INC.
3000 Town Center, Suite 2830, Southfield, Michigan 48075
(313) 352-3820

For more information, return completed coupon.

NAME

ADDRESS

CITY STATE ZIP

CONTACT ( ) PHONE

BOARD OF MEDICINE/*continued*

Violation
Failure to use reasonable care and discrimination in the administration of drugs, and failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease.

Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes.

• Ezra Shaya, MD
31170 Hoover Road
Warren, 48093

Date, Action Taken
October 1, 1980
License Reinstated

Violation
Shaya has satisfactority completed the terms and conditions of the probation as set forth in the final order dated October 13, 1978.

• Timothy L. Stern, MD
79 Shoreham Drive
Rochester, NY 14618

Date, Action Taken
November 4, 1980
Surrendered License

Violation
Prescribing, obtaining, possessing and using a schedule II controlled substance.

• Donald Y. Stewart, MD
Box #3919
Grand Central Station
New York City, NY 10017

Date, Action Taken
October 31, 1980
Intent to Deny Upheld

Violation
License was revoked effective February 1, 1979. Application for Reinstatement hearing took place on April 16, 1980 and license was Denied.

• Sigmond VonTitte, MD
7604 Fair Oaks, Apt. #1083
Dallas, TX 75231

Date, Action Taken
November 13, 1980
Revoked effective December 5, 1980

Violation
Fraud or deceit in obtaining a license.

A departure from or failure to conform to the minimal standards of medical practice.

• Norbert O. Anderson, MD
1060 E. Main Street, Box 589
Owosso, 48867

Date, Action Taken
November 14, 1980
Suspension from 1-5-81 to 1-5-83

Violation
A departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.

Failure to use reasonable care and discrimination in the administration of drugs, and failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease.

Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes.

• Roger G. Klaiber, MD
26084 Continental Circle
Taylor, 48180

Date, Action Taken
November 13, 1980
Suspension from 11-5-80 until complies with Order to Compel Examination

Violation
Failure or refusal to submit to an examination ordered by the board.

• Donald L. Salva, MD
6887 N. Lafayette
Dearborn Heights, 48127

Date, Action Taken
November 3, 1980
Revoked

Violation
Any conduct, practice, or condition which impairs or may impair, the ability to safely and skillfully practice the health profession.

Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

Conviction of a misdemeanor or felony reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner. A certified copy of the court record is conclusive evidence as to the conviction.

Nobel Prize winner to deliver Beaumont Lecture to Wayne County Medical Society

Doctor Yalow

Nobel Laureate Rosalyn S. Yalow, MD, will discuss her research in radioimmunoassay when she delivers the 60th Annual Beaumont Lecture of the Wayne County Medical Society.

The lecture is scheduled Monday evening, April 6, at Zuckerman Auditorium, Sinai Hospital of Detroit. A reception begins at 6 p.m., followed by dinner at 7, and the lecture at 8:15.

Beaumont Lecture chairman is Gilbert B. Bluhm, MD, Southfield.

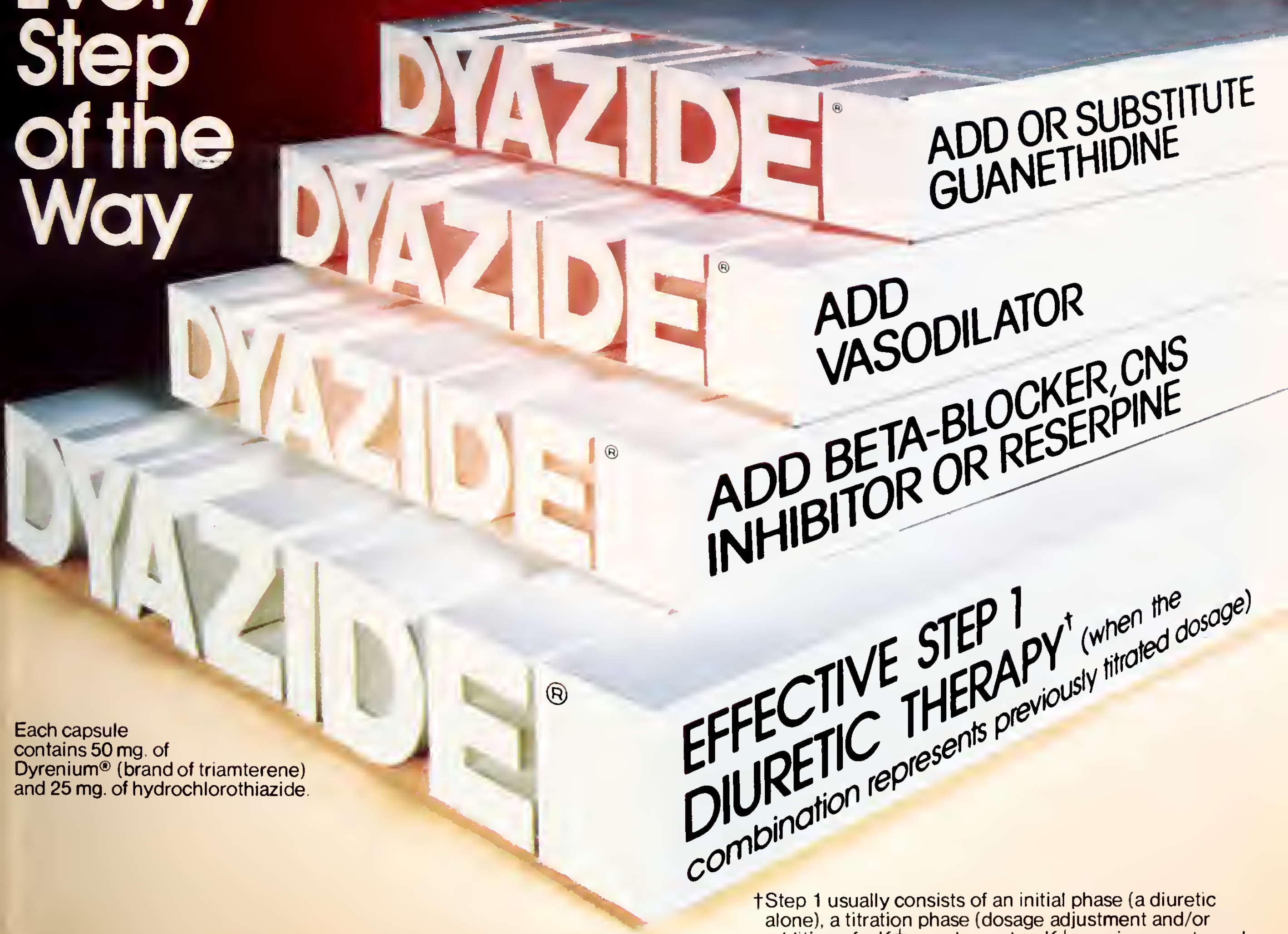
Doctor Yalow is senior medical investigator at Veterans Administration Hospital, Bronx, NY, where she also is chairman of the Department of Clinical Sciences, Montefiore Hospital and Medical Center.

Doctor Yalow received her Nobel Prize in Physiology and Medicine in 1977 for radioimmunoassay research.

Physicians attending her lecture may earn one hour of Category I CME credit. The registration fee for reception and dinner is $10. Reservations should be made with the Wayne County Medical Society, 1010 Antietam Road, Detroit, 48207.

In Hypertension*...When You Need to Conserve K^+

Every Step of the Way


DYAZIDE®
ADD OR SUBSTITUTE GUANETHIDINE
DYAZIDE®
ADD VASODILATOR
DYAZIDE®
ADD BETA-BLOCKER, CNS INHIBITOR OR RESERPINE
DYAZIDE®
EFFECTIVE STEP 1 DIURETIC THERAPY† (when the combination represents previously titrated dosage)

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

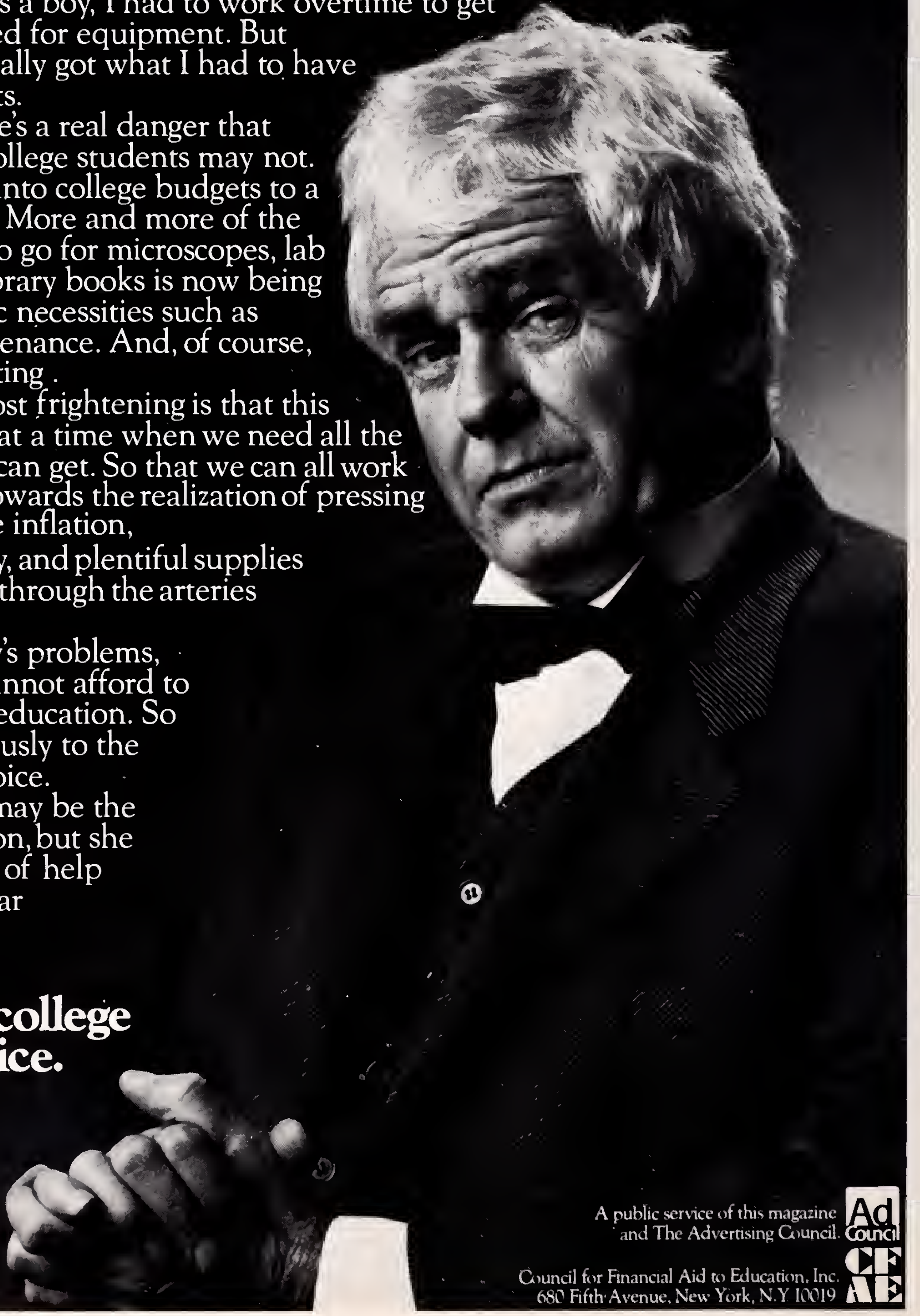
Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

©SK&F Co., 1980

SK&F CO.
a SmithKline company
Carolina, P.R. 00630

Colleges shouldn't have to choose between lighting their buildings and enlightening their students.

—Thomas Edison
Inventor



There's nothing more frustrating for a scientist than to be on the verge of a great discovery and not be able to afford the equipment he needs. I know.

When I was a boy, I had to work overtime to get the money I needed for equipment. But somehow I eventually got what I had to have for my experiments.

Today there's a real danger that many American college students may not. Inflation is eating into college budgets to a dangerous degree. More and more of the money that used to go for microscopes, lab equipment and library books is now being consumed by basic necessities such as heating and maintenance. And, of course, my specialty—lighting.

What is most frightening is that this squeeze is coming at a time when we need all the trained minds we can get. So that we can all work more effectively towards the realization of pressing goals: manageable inflation, revitalized industry, and plentiful supplies of energy coursing through the arteries of this country.

With today's problems, America simply cannot afford to have second-best education. So please give generously to the college of your choice.

Necessity may be the mother of invention, but she needs a great deal of help if she's going to bear children.

Help!
Give to the college of your choice.

A public service of this magazine and The Advertising Council. Ad Council

Council for Financial Aid to Education, Inc.
680 Fifth Avenue, New York, N.Y. 10019 CFAE

CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Psychoanalytic Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Northern Michigan Hospitals Inc., Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Michigan Psychoanalytic Society, Southfield
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital
Oakwood Hospital, Dearborn
Orthopedic Guild, Inc., St. Joseph
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

Date: March 17-20, Birth Defects: Biology, Recognition, and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School, Center for Human Growth and Development, the Department of Pediatrics and The Department of Postgraduate Medicine. **For:** All interested physicians. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: Mar. 22, 4th Annual Pediatrics Conference. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Department of Pediatrics, Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 7½ hours of Category I Credit.

Date: Mar. 26-27, Pancreatic Disease: Modern Approach To Diagnosis and Therapy. Location: U-M Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School Departments of Surgery, Postgraduate Medicine and Health Professions Education. **For:** All interested physicians. **Cost:** $220. **Contact:** Towsley Center for CME, 313/763-1400. **Approved for:** 15¾ hours of Category I Credit.

Date: March 27-28, Current Concepts in Clinical Microbiology: Antibiotic Susceptibility. Location: U-M Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **For:** All interested physicians. **Cost:** $100. **Contact:** Towsley Center for CME, 313/763-0081. **Approved for:** 13 hours of Category I Credit.

Date: March 27-28, Current Concepts in Pulmonary Rehabilitation. Location: Sheraton Inn and Borgess Medical Center, Kalamazoo. **Sponsor:** Borgess Medical Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Contact:** Charles L. Zeller, Jr., MD, Director/CME, SMAHEC, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 10 hours of Category I Credit.

Date: March 29, 23rd Annual Spring Clinic. Location: Valley View Restaurant, Shepherd. **Sponsor:** Central Michigan Community Hospital. **For:** All interested physicians. **Contact:** Frank D. Johnson, MD, Central Michigan Community Hospital, 1221 South Dr., Mt. Pleasant, 48858. **Approved for:** 7½ hours of Category I Credit.

Date: March 30-31, Emergency Psychiatry. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **For:** All interested physicians. **Contact:** Towsley Center for CME, G-2111, Box 057, University of Michigan, Ann Arbor, 48109. 313/764-2287. **Approved for:** 14 hours of Category I Credit.

Date: April 1, Common Problems of Altered Mental Status — A Clinical Approach. Location: Borgess Medical Center Auditorium. **Sponsor:** Borgess Medical Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Con-**

continued on page 130

family practitioners

Seeking board certified/eligible family practitioner to join three family practitioners, three general internists, a pediatrician, and a general surgeon in high quality group practice in a northern Wisconsin community. Clinic building adjoins community hospital. Associate membership, then membership affiliation with a large multispecialty medical group 100 miles distant which provides the full spectrum of consulting services and laboratory and administrative support and continuing medical education opportunities. Salary and fringe benefits excellent. Practice experience desirable but not mandatory. This is an excellent opportunity to practice family medicine with skilled colleagues in a small community environment while enjoying a reasonable call schedule, freedom from business administration, and the security of ready access to consulting specialists in all fields. Send curriculum vitae and names of persons who can be contracted for reference to:

HOWARD CHATTERTON, M.D.
906 College Avenue, West
Ladysmith, WI 54848

MEETINGS

MSMS, MSMS/A, AMA and medical assistants

Mar. 25-26 — 20th Annual Michigan Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

Apr. 9 — MSMS Conference on Sports Medicine, Western Michigan University Student Center, Kalamazoo, contact: Mert Scholten, MSMS headquarters.

Apr. 23-25 — 77th AMA Congress on Medical Education and Licensure, Palmer House, Chicago, contact: Department of Meeting Services, AMA, 535 N. Dearborn, Chicago, 60610.

Apr. 23-26 — Annual meeting, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn, Lansing, contact: Caroline Rich, MSMS headquarters.

Apr. 27-29 — 55th annual convention, MSMS/A, Marriott Inn, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

May 1-3 — MSMS House of Delegates, Troy Hilton, contact: Richard Campau, MSMS headquarters.

May 5-14 — MSMS/Intrav Canadian Rockies Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

July 16-19 — MSMS Council, Grand Traverse Hilton, contact: Warren Tryloff, MSMS headquarters.

Sept. 9 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 21 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 17-18-19 — 1981 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

Mar. 14-15 — Regional Conference on the Impaired Professional, Hilton Inn North, Worthington, OH, contact Marcelyn Ireland, MSMS headquarters.

Mar. 16 — Annual membership meeting, Michigan Chapter, American College of Emergency Physicians, Harley Hotel, Lansing, contact: Michigan Chapter, ACEP, 1305 Abbott Rd., Suite 102, East Lansing, 48823. 517/332-6500.

Apr. 6 — 60th Annual Beaumont Lecture, Wayne County Medical Society headquarters, contact: WCMS, 313/567-1640.

Apr. 9 — Mid-Winter Meeting, Michigan Academy of Family Physicians, Fairlane Manor, Dearborn, contact: MAFP, 416 N. Homer, Suite 107, Lansing, 48912.

Apr. 23 — Council Meeting, Michigan Psychiatric Society, Detroit, contact: Helen Schulte, MSMS headquarters.

Apr. 30 — Annual Meeting, Michigan Society of Thoracic Surgeons, Hyatt Regency Dearborn, contact: Rodman E. Taber, MD, 30050 Hoover Road, Warren, 48093.

May 26-28 — 60th Annual Conference, Michigan Public Health Association, Sheraton Southfield Hotel, contact: MPHA, 1407 S. Harrison, Suite 340, East Lansing, 48823.

July 29-30 — 24th Annual Congress of Delegates meeting, Michigan Academy of Family Physicians, Holiday Inn, Traverse City, contact: Loretta Joyce, Executive Director, MAFP, 416 N. Homer, Suite 107, Lansing, 48912.

Aug. 28-30 — Summer meeting, Michigan Psychiatric Society, Holiday Inn, Traverse City, contact: Helen Schulte, MSMS headquarters.

Michigan State Medical Society

INTRAV®

ITALIAN

ADVENTURE

An 11-Day Visit to the Best of Italy
VENICE • FLORENCE • ROME
With an Optional Extension to NAPLES, POMPEII, SORRENTO AND CAPRI

Departing Chicago and Detroit on September 18, 1981

Take a gondola ride on the Grand Canal. Relax on St. Mark's Square. Shop for gloves and Italian fashions on Venice's Rialto Bridge. See the fabulous art and architecture of Florence. See Michelangelo's "David."

Visit St. Peter's and the Vatican in Rome. See Tivoli, Hadrian's Villa and the gardens of Villa d'Este.

Join our optional three-day extension to Naples, Pompeii, Amalfi and Capri.

Italian Adventure...great sightseeing
great food and effortless travel with INTRAV.

$1999 from New York

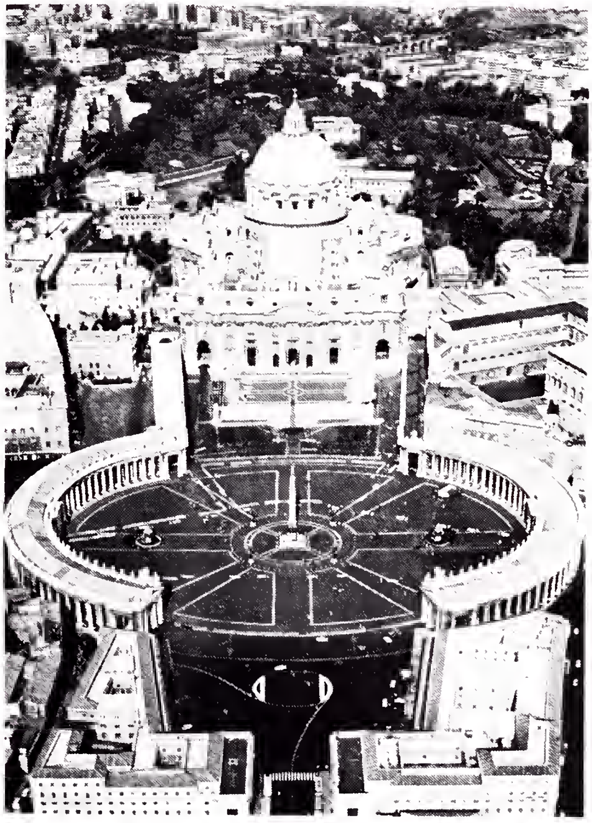
Where...
Venice
Florence
Rome

Via...
Alitalia Airlines Wide-Bodied
Transatlantic Jet

Length...
Eleven Days

Limited Group...
Exclusive INTRAV group limited
to 80 passengers

Hotels...
Bauer Grunwald in Venice
Baglioni Hotel in Florence
Cavalieri Hilton in Rome



Dining...
American breakfast each morning
at your hotel. Dinners each
evening at a selection of the finest
restaurants

Party...
Get Acquainted Wine and
Cheese Party

Escort...
Travel Director throughout Italy

Assistance...
Hospitality Desk to assist you

Sightseeing...
A full choice of optional excursions
including a three-day/ two-night
extension to Naples, visiting
Pompeii, Sorrento and Capri

Send to: Michigan State Medical Society
120 West Saginaw
E. Lansing, MI 48823

Enclosed is my check for $ _____
($200 per person), as deposit

Name ____________________

Home Address ____________________

City ____________ State ________ Zip ________

A Non-Regimented INTRAV® Deluxe Adventure

CATEGORY I/*continued*

tact: Charles L. Zeller, Jr., MD 252 East Lovell, Kalamazoo, 49007. **Approved for:** 6 hours of Category I Credit.

Date: April 1-4, Aesthetic and Reconstructive Surgery of the Head and Neck. Location: Campus Inn, Ann Arbor. **Sponsor:** Department of Otolaryngology, University of Michigan Medical Center. **For:** All interested physicians. **Cost:** $500. **Contact:** Shan R. Baker, MD, Dept. of Otolaryngology, University of Michigan Medical Center, Ann Arbor, 48109. **Approved for:** 28 hours of Category I Credit.

Date: April 9-10, Disaster Management: The Critical Hours. Location: St. Joseph Mercy Hospital Education Center, Ann Arbor. **Sponsor:** Michigan Chapter, American College of Emergency Physicians, and Emergency Medicine Foundation and Department of Emergency Medicine of St. Joseph Mercy Hospital. **For:** All interested physicians. **Contact:** Catherine C. Sleicher, Executive Director, Michigan Chapter, ACEP, 1305 Abbott Road, Suite 102, East Lansing, 48823. 517/332-6500. **Approved for:** 14 hours of Category I Credit.

Date: April 10-11, Disease Prevention/Health Promotion: The Family as the Focus for Health Promotion. Location: Sheraton-Southfield Hotel, Southfield. **Sponsor:** Department of Family Medicine/Practice, Michigan State University, University of Michigan and Wayne State University. **For:** All interested physicians. **Contact:** Wayne State University School of Medicine, Division of CME, 4201 St. Antoine, 9B-32 DRHUHC, Detroit, 48201. 313/577-1180. **Approved for:** 9 hours of Category I Credit.

Date: April 11, Breast Cancer. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, **517/**353-8822. **Approved for:** 8 hours of Category I Credit.

Date: April 11-12, Conception and Misconception: Important Endocrine Problems Affecting Women. Location: Henry Ford Hospital's Education & Research Center, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 12 hours of Category I Credit.

Date: April 15, Pediatric Seminar V. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22101 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: April 15, Conference on Adolescent Medicine. Location: St. Lawrence Hospital. **Sponsor:** Michigan State University School of Human Medicine and School of Osteopathic Medicine, Michigan Academy of Family Physicians, St. Lawrence Hospital, and Central Michigan Pediatric Society. **For:** All interested physicians. **Cost:** $25. **Contact:** Andrew Hunt, MD, A110 E. Fee Hall, MSU, 517/355-7550. **Approved for:** 6 hours of Category I Credit.

Date: April 22-23, New Directions in Care for the Handicapped Child. Location: Grand Rapids. **Sponsor:** American Academy of Pediatrics. **For:** All interested physicians. **Cost:** $75. **Contact:** Jean Dow, American Academy of Pediatrics, 1-800-323-0797. **Approved for:** 16 hours of Category I Credit.

Date: April 22-24, Computerized Treatment Planning Systems Symposium. Location: Buerki Auditorium, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** $150. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 19½ hours of Category I Credit.

Date: April 23-25, Critical Care Symposium. Location: Wayne County Medical Society Headquarters. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Theresa Sokol, WSU School of Medicine, Department of Surgery 6C University Health Center, 4201 St. Antoine, Detroit, 48201. **Approved for:** 15 hours of Category I Credit.

Date: April 25-29, Advanced Muscle Energy Tutorial. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Date: April 27-29, Echocardiography — State of the Art. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan Heart Association and the American Heart Association Council on Clinical Cardiology. **For:** All interested physicians. **Contact:** Michigan Heart Association, P.O. Box 160-LV, Lathrup Village, 48076. 313/557-9500. **Approved for:** 15 hours of Category I Credit.

Date: May 9, Testicular Biopsy in Fertility Disorders and Unusual Pathologic Conditions of the Testes and Adnexa. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Michigan Society of Pathologists. **For:** All interested pathologists. **Contact:** Willys F. Mueller, MD, Department of Pathology, Hurley Hospital, Flint, 48502. **Approved for:** 3 hours of Category I Credit.

Date: May 14, Major Problems in Adolescence. Location: Kalamazoo Hilton. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** $55. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 16-18, Michigan Dermatological Society Central States Meeting. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Dermatological Society. **For:** All dermatologists. **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hours of Category I Credit.

Date: May 20, Family Practice Update. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 20, Second Annual Regional Medical Conference on Infectious Disease. Location: Southwest Michigan College, Dowagiac. **Sponsor:** Lee Memorial Hospital. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Cost:** $50 for physicians. **Contact:** Judith B. Willis, Assistant Director/Regional Medical Education, SMAHEC, 252 East Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 22, Third Annual Associate Member Meeting. Location: Wayne State University, McGregor Conference Center. **Sponsor:** Michigan Chapter, American College of Physicians. **For:** Internists. **Contact:** Ralph Cushing, MD, FACP, Wayne State Univeristy, 313/577-5084. **Approved for:** 5 hours of Category I Credit.

Date: June 1-5, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine. Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

Date: July 9-12, Eighth Annual Michigan Emergency Medicine Assembly. Location Grand Hotel, Mackinac Island. **Sponsor:** Michigan Chapter, American College of Emergency Physicians. **For:** All interested physicians. **Contact:** Catherine C. Sleicher, Executive Director Michigan Chapter, ACEP, 1305 Abbott Road Suite 102, East Lansing, 48823. **517/332-6500** **Approved for:** 26 hours of Category I Credit.

Date: June 15-19, Basic Principles of Manua Medicine. Location: Kellogg Center, MSU, Eas Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn Coordinator CME, 517/353-8822. **Approved for** 40 hours of Category I Credit.

Date: June 19-21, Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club Gaylord. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Benjamin Henig, MD, Keyport Clinic, 308 Michigan Ave., Grayling, 49738 **Approved for:** 12 hours of Category I Credit.

Date: June 19-21, Michigan Dermatologica Society Annual Meeting. Location: Renaissance Center, Detroit. **Sponsor:** Michigan Dermatological Society. **For:** All interested dermatologists **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hour of Category I Credit.

Date: July 26-29, 13th Annual Summer Conference. Location: Grand Hotel, Mackinac Island **Sponsor:** Michigan Opthalmological Society **For:** All interested opthalmologists. **Contact** Philip C. Hessburg, MD, 15401 E. Jefferson Grosse Pte. Park, 48230. **Approved for:** 8 hour of Category I Credit.

Date: Aug. 18-21, Michigan Health Officers Association Annual Meeting. Location: Holiday Inn, Traverse City. **Sponsor:** Michigan Health Officers Association. **For:** All interested physicians and health officers. **Contact:** William W Moon, MD, Box 43, Harrietta, 49638. **Approved for:** 5 hours of Category I Credit.

Date: Oct. 11-15, 1982, Abortion: Spontaneous and Induced. Location: Maui Surf Hotel, Maui Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University Schoo of Medicine, 550 E. Canfield, Detroit, 48201 313/577-1011. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-15, 1982, CDS: Contraceptive Delivery Systems. Location: Maui Marriott Hotel Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University Schoo of Medicine, 550 E. Canfield, Detroit, 48201 313/577-1101. **Approved for:** 29 hours of Category I Credit.

Administrative office
and main laboratory

AMRC the full service laboratory

- Complete range of individual tests and diagnostic profiles
- Medical consultation services
- Comprehensive quality control program
- Fully accredited
- Complete billing service

Advance Medical &
Research Center, Inc.

1270 Doris Rd • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

Since 1899

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

DETROIT OFFICE
R. K. Wind, J. K. Gallaway, T. A. Weisman, and W. M. Backus, Representatives
6785 Telegraph Road, Suite 350, Birmingham 48010
Telephone (313) 647-6640
GRAND RAPIDS OFFICE: G. J. Hawarth, Representative
143 Cartland Avenue, Rockford 49341, Telephone (616) 866-9395

Now. . .today's issues in anxiety management are confronted in a unique program for primary care physicians

Anxiety: the therapeutic dilemma

Multimedia Continuing Education Program

Anxiety: the therapeutic dilemma
Participant Kit
Anxiety: the therapeutic dilemma
Anxiety: the therapeutic dilemma
1 Clinical Relatio
Anxiety

Ideas about anxiety management are changing. Problems have surfaced. There is concern about dependence on minor tranquilizers and new findings on receptor sites in the brain. There is a trend toward short-term therapy and interest in nondrug alternatives. Because anxiety can disable, the need to treat continues in daily practice. Primary care physicians require up-to-date information.
This program can provide it.

Current Views and Opinions from Eminent Authorities

Offered free of charge, this multimedia seminar is based on a major symposium. It integrates the views of nationally known clinicians with case material to demonstrate: 1) keys to differential diagnosis, 2) recognition and management of dependence-prone patients, 3) ways to minimize tranquilizer dependency, 4) guidelines for selecting drug and nondrug therapies, 5) how the biochemistry of anxiety can affect treatment modalities. And more.

CME Accreditation

The complete program, **Anxiety: the therapeutic dilemma**, is designed to provide up to a total of 26 credit hours in Category 1, PRA/AMA. The maximum number of hours may be obtained as follows:

Seminar(s)

When presented by an accredited CME provider (hour for hour) . . . up to 8 hours

Self-Study Programs

Designed to provide credit hours indicated when completed according to instructions:

- Two monographs (completed as a unit) . . . up to 6 hours
- Six self-study units (2 hours each) . . . up to 12 hours

Unique Interactive Format Stimulates Participation

More than a conventional lecture, this seminar provides opportunity (and guidance) for the kind of interaction that promotes understanding and anchors useful ideas. Guest lecturers are available and all elements needed for an effective program are included: films, moderator's guide, participants' workbooks, monographs, publicity material, etc.

Flexible Program Design

Anxiety: the therapeutic dilemma is a versatile program with an outstanding faculty, pertinent content and lively format. It can be conducted in a variety of ways to meet your scheduling needs: • Full day — 8 hour seminar • Half day — 4 hour seminar • 1 or 2 hour course

For further information, mail the coupon below, or call toll-free 800-526-4299. In New Jersey, call (201)-636-6600.

Anxiety: the therapeutic dilemma

was produced under a grant from Abbott Laboratories

1-0791 1033394

M.E.D. Communications
655 Florida Grove Road
Hopelawn, NJ 08861

Please send me full details on faculty, agenda, accreditation and booking for the CME seminar, **Anxiety: the therapeutic dilemma.**

Name
(please print)
Title
Institution
Street
City State Zip

MAFP 10-state conference-goers hear patient understanding key to prevention

By Jeffrey Rich, special to Michigan Medicine

"In medical care, professional expertise is of prime importance. But in prevention, it is patient understanding that is paramount."

That is the opinion of Ann Somers, DSC, professor, Rutgers University Department of Community Medicine. Speaking at the Michigan Academy of Family Physicians Regional Conference on Patient Education (Jan. 30-Feb. 1, Dearborn) Ms. Somers advocated a more active role for the public if disease prevention is to make any significant gains.

The concepts of patient "compliance" and "non-compliance" are too authoritarian, she said. They should be abolished from physicians' vocabularies and replaced with the idea of "patient responsibility."

Since the inception of third party payment, she continued, the public has confused the terms "health care" with that of "health," leading to the loss of the individual's sense of responsibility for their own state of well-being.

Jack Medalie, MD, chairman, Department of Family Practice, at Case Western Reserve Medical School, emphasized the need to not only "communicate," but also to "integrate" information into patients' lives. Doctor Medalie recalled a Chinese proverb demonstrating his point: "Tell me, I'll forget; show me, I may remember; involve me, and I'll understand." The most successful health campaigns are those integrated with the daily life of the consumer, taking into account their particular psycho-social environment, he said.

Citing the importance of supportive mechanisms in disease prevention, Doctor Medalie discussed the findings of a study dealing with the prevalence of stress-related illnesses among married, single, divorced, and widowed men. Cardio-vascular disease, for example, was lowest among the married group. Without benefit of an in-depth qualitative analysis, Doctor Medalie briefly spoke of the positive effects of a loved one's attentions on health.

If patients are to be expected to learn more about their roles, then physicians will be required to become better teachers. Director of the Family Practice Residency Program in Danville, Indiana, Ross Eggers, MD, spoke of the need to apply proper training to communicate effectively. He is part of a program using videotapes of residents' patient relationships, and measuring the effectiveness of their communications. In reviewing tapes, numerical values are assessed each phase of the interaction, allowing the resident t monitor his/her strengths and weaknesses. Doctor Eggers reports stead improvement in scores on all of th residents, indicating their increase understanding of patients' needs.

It is one of Doctor Eggers' goal to increase patients' sense of responsibility in their health matters, whicl he feels can be better achieved by involving them in the diagnostic process. He uses their own comments i defining the problem, and include the patient in deciding on a course o treatment.

In Michigan, continuing education for practicing physicians is th focus of considerable MAFP interest said Academy President Gary Ruof MD, Kalamazoo, during the confer ence. In the process of simplifyin the American Academy of Famil Physicians self-assessment forms aimed at determining a more effective core curriculum for continuin education, Doctor Ruoff announce plans to audit 25 state members monitoring the application of educational programs to clinical practice If, as Grahame Owen, MD, Ontario put it, education is seen as "instillin the desire for more knowledge" the it must begin with the physician.

Lawrence Green, DPH, professo at Johns Hopkins University and D rector of Health Information at th U.S. Department of Health an Human Services, discussed three ke behavioral problems hindering effective education in preventiv medicine: drug errors, patient cooperation, and lifestyle.

The error factor in drug sel administration programs correlates t the degree of complexity confrontin the consumer. The lack of access t easily understood information at th time of ingestion is a major dete minant of patient non-compliance Over the counter drugs were found t be packaged with complicated an technical inserts, resulting in confu

University of Michigan Credit Available
for study tour
21 days in PRC +
Manila and Hong Kong

CHINA!

May 21 to June 17
HEALTH CARE SYSTEMS
visits to hospitals, clinics, schools, training programs for physicians, nurses, etc; and major tourist sites in Beijing, Guilin, Xian, Shanghai and four other cities.

(June 22 to July 19, Education and Schools)
ONLY $3332.00 from S.F.

Act Now! Visa deadline for May is Mar. 22; (call and check if later) Professor Robert Hefner, U. Michigan 589 Union Dr., Ann Arbor, MI 48109 (313) 763-4355 day 662-1867 eve and weekends.

LIMITED SPACE AVAILABLE!

ion to the lay person as to the purpose and potential effects of the nedication. Prescribed drugs were ound to be more successful when ccompanied by physician counseling, though all too often the patient emembers less than is desirable, anging from 38 to 54 percent, ac ording to four of Doctor Green's tudies of patient recall. The most ef icient program of all has been that of horough counselling combined with he Dosett* type medication dis enser, offering the user an easily nderstood schedule of ingestion.

Prof. Green saw problems with atient cooperation as more than hose of following a physician's ad ice in drug administration. Broken ppointments are another hindrance o the medical process. The patient's ailure to arrive leads to wasted staff ime, which is compensated for by ver-scheduling. This all too often esults in extended time in the wait ng room for patients, predisposing to a less satisfying experience with the clinical visit, and perhaps, future broken appointments. The Ohio Academy of Family Physicians' pamphlet on "Consumerism" was referred to as a positive step towards minimizing this cycle. In this booklet, many common consumer questions and grievances are addressed in a simple and straightforward manner.

The lifestyle problems Prof. Green spoke of were the list of high risk factors from the Surgeon General's Report (Healthy People 1979), which account for as much as 70% of the annual mortalities in the United States. The probable figure for influence on morbidity is even higher. With a cartoon showing a patient saying to his doctor, "My problem is, I don't think I have a lifestyle," Prof. Green said that issues such as smoking, alcohol, obesity, fitness, stress, nutrition, and others in SGR were major obstacles to disease prevention programs today.

EMF

EMERGENCY MEDICINE FOUNDATION

A gift to the Emergency Medicine Foundation in tribute to someone you wish to honor will advance research and education in emergency medicine. Your thoughtfulness will be appropriately acknowledged.

EMERGENCY MEDICINE
FOUNDATION
3900 Capital City Blvd
Lansing, Michigan 48906

Summer Cruise/Conferences on Legal-Medical Issues

APPROVED FOR
23 CME CREDITS
CATEGORY I

By the American College of Legal Medicine
Seminars Directed by Irwin N. Perr, M.D., J.D.
Professor, Rutgers Medical School

Caribbean Conference — July 29 — August 8, 1981 aboard TSS Fairwind.* Visit St. Maarten, Antigua, Barbados, Martinique and St. Thomas.

Mediterranean Conference — August 22 — September 5, 1981 aboard Mts. Danae.** Visit major cities in Italy, Greece, Egypt, Israel, Turkey, Yugoslavia.

- All meals on cruise and aloft.
- Seminars conducted at sea.
- Alitalia scheduled flights to Italy.
- Excellent Fly/Cruise group rates.
- Hotel Danieli — Venice, Italy
- All transfers

The number of participants in each Conference is limited. Early registration is advised.

For color brochure and additional information contact:

International Conferences
189 Lodge Avenue
Huntington Station, N.Y. 11746
Phone (516) 549-0869

Both conferences are designed to conform with the 1976 Tax Reform Act.

*Liberian Registry
**Greek Registry

SPECIFY
ZYLOPRIM®
(allopurinol)
THE ORIGINAL ALLOPURINOL

ZYLOPRIM
U4A

Two convenient dosage forms: 100 mg (white) and 300 mg (peach) Scored Tablets

ZYLOPRIM
C9B

Tablets imprinted with brand name to assist in tablet identification.

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

MEDICAL NEWSFRONTS

Between January 22nd and January 28th six additional cases of Reye's Syndrome were reported to MDPH. Four of these children had onset of symptoms of Reye's Syndrome the week of January 19th. Two had onset the week of January 26th. These six cases ranged in age from seven months to 17 years old. Two of these children reached stage three or greater. All six of the cases experienced a respiratory illness prodrome.

Their cases are in addition to the five reported since Sept. 1.

The state of Ohio has received reports of 11 cases of Reye's Syndrome in December and January. The Province of Ontario has received informal reports regarding six possible cases in January. Little evidence of Reye's Syndrome activity has been reported in Wisconsin, Minnesota and Indiana.

The Michigan Department of Public Health continues to receive reports of school closings due to influenza-like illness scattered over the state. Approximately 20 percent of the isolates obtained so far this year have been A/Brazil/1/78-like. The others have been A/Bangkok/1/79-like. We expect influenza-related illness to peak and begin to decline.

Reye's Syndrome should follow the same pattern. We should also soon begin to see chickenpox-related Reye's Syndrome as the Varicella virus season begins.

Despite a recent report to the contrary, high fat diets can bring on coronary artery disease, according to a new University of Michigan research report.

Nearly twice the rate of heart disease deaths was reported among persons on high fat diets in an epidemiologic study of a community in West Scotland, according to the U-M scientific paper.

Victor M. Hawthorne, MD, professor and chairman of the U-M School of Public Health epidemiology department, presented the paper on "Cholesterol — Vital Statistics, Not Value Judgements" at the recent annual meeting of the American Public Health Association.

His presentation followed the earlier report by National Academy of Sciences's Food and Nutrition Board which stated that "there is no scientific evidence that a reduction in fat consumption or a reduction in cholesterol intake could be claimed to reduce coronary artery disease."

Doctor Hawthorne notes in his paper that "the authors of the controversial (Academy) report have surprisingly chosen to omit the epidemiological evidence, yet only epidemiology (population health studies) can resolve some of the doubt for the present."

In the epidemiologic study of 5,616 adult males in the working population of the West Scotland area cited by the U-M professor, the death rate per 1,000 from heart disease over a five-year period for those with low blood cholesterol levels (260 milligrams or less per 100 cc) was 7.6.

For those with moderate levels (261 to 290 mg.), however, the heart disease death rate jumped to 19.2 per 1,000, and for those with high levels (over 290 mg.) to 21.9 per 1,000.

Cigarette use among American young people is now declining sharply, members of The University of Michigan's Institute for Social Research have found in a series of national surveys.

In a report about to be published by the sponsoring agency, the National Institute on Drug Abuse, three U-M social scientists state "perhaps the most dramatic change in substance abuse now taking place among American young people is the sharp drop in regular cigarette smoking."

Although they warn that "the problem has not gone away," the U-M researchers suggest that "public health campaigns dealing with smoking may well have had an important impact on the young."

Babies who were fed low chloride infant formulas may have been exposed to serious growth and health problems.

Infant formulas sold under the brand names of Neo-Mull-Soy® and CHO-free® were found to be low in chloride between the summer of 1978 and a year later when they were withdrawn from the market.

These formulas are generally given to infants with food allergies. Infants who have received Neo-Mull-Soy® or CHO-free® and had no acute ill effects are unlikely to have long-term problems attributable to the use of these formulas.

Cases of hypochloremic metabolic alkalosis were reported in some infants who had been fed these formulas without other foods. These infants showed lethargy, failure to thrive, loss of appetite and constipation. Recovery and catch-up growth began when adequate chloride was added to the infants' diets or when infants were changed to other formulas.

Physicians or parents with any information about health problems in infants who have been fed these chloride-deficient formulas should contact Jose F. Cordero, MD, Birth Defects Branch, Chronic Diseases Division, Bureau of Epidemiology, Centers for Disease Control, Atlanta, 30333 (404/452-4035).

A new program to find former coa miners suffering from black lung disease and treat them for it has jus started at Henry Ford Hospital, Detroit.

Persons who have worked in o around coal mines in the Unite States are eligible to apply for medical and financial benefits. Widows o other dependents of deceased coa miners may also be eligible for compensation if their miner-relative ha the disease and was totally disable by it.

Dr. Michael S. Eichenhorn, MD and Paul A. Kvale, MD, are co directors of the Black Lung Clinic, part of the Division of Pulmonar Medicine at Henry Ford Hospital.

The Black Lung Clinic at Henr Ford Hospital has been establishe under a grant from the US Department of Health and Human Services

"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

PAVABID® AND PAVABID® HP
(papaverine hydrochloride)
150-mg Capsules 300-mg Capsulets

Patient benefit products from

PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY MO 64137

6/80

DEATHS

Robert F. Berry, MD
Marquette

Robert F. Berry, MD, Marquette, died March 27 at the age of 71. Doctor Berry received his MD from Loyola Medical School in 1932. For over 10 years he served as superintendent of the Acocks Medical Care Facility. He was a member of the American College of Surgeons and served as past president of the Marquette-Alger County Medical Society.

Rudolph I. Clary, MD
Dowagiac

Rudolph I. Clary, MD, Dowagiac, died Dec. 16. He was 73. Doctor Clary earned his MD from the University of Michigan Medical School in 1931. During World War II he served in the medical corps of the US Navy in the Philippines and the South Pacific. Until his retirement in 1968, Doctor Clary maintained a private practice in Dowagiac.

Edward D. Coppola, MD
East Lansing

Edward D. Coppola, MD, East Lansing, died Jan. 9 at the age of 50. Doctor Coppola was instrumental in setting up the Michigan Transplantation Society and a kidney transplant program between Edward W. Sparrow Hospital and the MSU College of Human Medicine. He received his MD from Yale in 1955. He was a diplomate of the National Board of Medical Examiners, a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons. In 1966 he was awarded a six-year John and Mary R. Markle Scholarship in Academic Medicine. At the time of his death, Doctor Coppola served as professor of surgery at MSU.

Frank S. Fordell, MD
Allen Park

Frank S. Fordell, MD, Allen Park, died Dec. 18. He was 77. Doctor Fordell earned his MD from the University of Michigan Medical School in 1929. He maintained a private practice in the southwest Detroit area until his retirement in 1970. After retirement, he became a part-time physician for the Ford Motor Company.

William W. Jack, MD
Drummond Island

William W. Jack, MD, Drummond Island, died Dec. 20 at the age of 65. Doctor Jack received his MD from the University of Michigan Medical School in 1942. He practiced obstetrics and gynecology at Blodgett Hospital from 1949 until his retirement in 1975. From 1962 until 1964 he served as Blodgett's chief of staff. Doctor Jack also was former chairman of the MSMS Maternal Health Committee.

Dwight J. Mosier, MD
Bay City

Dwight J. Mosier, MD, Bay City, died Jan. 1. He was 76. He earned his MD in 1929 from Northwestern University Medical School. Doctor Mosier served as chief of staff of the former General Hospital, and as a board member of the Bay Medical Care Facility, Hampton Manor, Colonial Nursing Home and the Tri-City Nursing Center. He was a member of the American College of Chest Physicians and served as past president of the Bay-Arenac-Iosco County Medical Society.

Robert A. Ostrander, MD
Tucson, AZ

Robert A. Ostrander, MD, Tucson AZ, died Dec. 31 at the age of 73 Doctor Ostrander earned his MD from the University of Michigan Medica School in 1937. He retired from practice in 1964. He was a member of th American Society of Anesthesiologists and served as past presiden of the Mason County Medical Society.

Carver G. Walcott, MD
Fenton

Carver G. Walcott, MD, Fenton, died Dec. 23. He was 78. He received his MD from the University of Michigan Medical School in 1934. During World War II, Doctor Walcott received the American Legion of Meri award for his service as a surgeon aboard ship in the Mediterranean Sea, Africa and Italy. He served on the staffs of Hurley Medical Center McLaren General Hospital and St Joseph Hospital. He was also a member of the American College o Emergency Physicians.

William J. Weber, MD
Grand Blanc

William J. Weber, MD, Grand Blanc died Jan. 11 at the age of 50. Doctor Weber received his MD from the University of Michigan Medica School in 1958. He served as chief o cardiology at Hurley Medical Center In 1973 he installed the first nuclear pacemaker in Michigan. He was a member of the American Society of Internal Medicine, the Michigan Heart Association, the American College of Chest Physicians, the Society for Computer Medicine, and the President's Club of the University of Michigan.

Cornelius B. Wood, MD
Mt. Pleasant

Cornelius B. Wood, MD, Mt. Pleasant, died Jan. 3. He was 74. He earned his MD from the University of Michigan Medical School in 1930. He was a fellow of the American College of Surgeons, and the International College of Surgeons. He maintained a private practice in Mt. Pleasant until 1967.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When **impotence** is due to androgenic deficiency.

Android® /5 Buccal mg. /10 Oral mg. /25 Oral mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

OBSTETRICS AND GYNECOLOGY — Grad Year II — Unexpected opening July 1, 1981 in fully accredited 4 year program in large community teaching hospital. For information call or write Dept. of Health Educ., St. John Hospital, 22101 Moross Rd., Detroit, MI 48236. 313-343-3875.

WANTED: Primary physician or surgeon to join busy family and industrial practitioner. Fully equipped office, maximum para-medical assistance including P.A. Finances open, immediate housing available. Phone 313-329-3555 or 982-5165.

FORT WAYNE, INDIANA — EMERGENCY DEPARTMENT PHYSICIANS. American Medical Services Association, Inc., a Kansas City based multiple hospital physician group, is seeking career oriented primary care and emergency care physicians who are: board eligible or certified, show an affinity for the team concept of medical practice, business oriented, show professional maturity and judgment, have a keen desire to succeed, committed to CME. We are successful because we offer the unique package of salary and benefits in the health care industry. All of our physicians participate in the ownership of the company. If you feel qualified, we are interested in you. Contact: Michael P. Colucci, Vice-President of Marketing and Recruitment, American Medical Services Association, Inc., 4400 Broadway — Suite 306, Kansas City, Missouri 64111. 816-931-3040.

ONCOLOGY FELLOWSHIP — 1 or 2 year program in 550 bed teaching community hospital with fully approved residency programs in internal medicine, general surgery, ob/gyn, pediatrics and pathology. Requirements: Completion of 3 year internal medicine residency. For information contact Dept. of Health Educ., St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

NEPHROLOGY FELLOWSHIP — 1 or 2 year program in 550 bed teaching community hospital with fully approved residency programs in internal medicine, pediatrics and general surgery and 16 station out-patient esrd. Requirements: Completion of 3 year internal medicine residency. For information contact Dept. of Health Educ., St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

NEUROSURGERY FELLOWSHIP — 1 year program in 550 bed teaching community hospital, a designated trauma center, with fully approved 5 year general surgery residency. Requirements: Completion of neurosurgery residency. For information contact Dept. of Health Education, St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

CALIFORNIA-DIRECTOR POSITIONS AVAILABLE. Emergency medicine physicians needed for rural Northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610. 415/832-6400.

SOUTHWESTERN MICHIGAN EMERGENCY GROUP, located on the lovely shore of Lake Michigan, desires a fifth member for a flourishing hospital based group having 32,000+ patient visits a year and equipped with latest in field telemetry and paramedic services. Work an average of 35 hours weekly for $50,000 year one with liberal fringes. Only full time career oriented ER doctors, please. Contact Edwin Vann, PhD, MD, at 616/429-9714 or 983-8213 in Saint Joseph.

FAMILY PRACTITIONER, GENERAL SURGEON, PEDIATRICIAN — To locate in Sandusky, a small community with a 49 bed acute care hospital located near Lake Huron. Newly completed medical clinic building adjoining the hospital with office space available. Established pediatric practice ready to be assumed. For further information contact: Joseph W. Weiler — Administrator, McKenzie Memorial Hospital, 120 Delaware, Sandusky, Michigan, 48471, 313/648-3770.

FAMILY PRACTITIONERS. Opportunity available in Edmore, northeast of Grand Rapids, Michigan. Financial assistance available to establish practice. For details, send curriculum vitae, or call collect Recruitment Director, Adventist Health System North, 15 Salt Creek Lane, Hinsdale, Illinois, 60521, 312/920-1100.

KENTUCKY TOWN NEEDS GP — friendly town in eastern Kentucky, has hospital in adjacent city with complete services and specialists. The hospital and community will provide a complete financial package to insure a successful practice. All replies kept confidential. Contact Administrator, Box 12, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

OB/GYN PARTNERSHIP — Young ob/gyn located in Southern Illinois, with an expanding practice, needs a partner. This pleasant community is family oriented, with good schools and a new hospital. All replies will be kept confidential, send to Box 14, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

MISSOURI OB/GYN, group opportunity with four family practitioners. Offices adjacent to hospital. Excellent family area, with relaxed life style in small town, near several large cities. Attractive financial arrangements. Send replies in confidence to Box 13, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

PARTNER NEEDED — by Arkansas GPs — two established physicians with office near hospital need third physician GP or internist for busy practice located in the beautiful Bull Shoals area. Attractive financial arrangements. Send replies in confidence to Box 11, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

GENERAL PRACTICE FOR SALE — Flint, Michigan, due to retirement. Office for one or two doctors available immediately. Grossing in 6 figures. No ob. No medicaid. Replies to Box 15, MSMS, 120 W. Saginaw, East Lansing, MI 48823.

PEDIATRIC RESIDENCY — Grad Year II — Unexpected opening for July 1, 1981 in fully approved three year program in large community teaching hospital. Write or call, Dept. of Health Educ., St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

LOCUM TENENS — Pediatrician wanted to cover practice in a beautiful resort area, beginning June 12 til July 12, 1981 for either tv
weeks or the entire period. Compensatic
negotiable. Please contact: Nora F. Chan
MD, FAAP, 828 Oak St., Cadillac, MI 4960
Phone: 616/775-4696.

PATHOLOGY RESIDENCY — Grad Year I
Unexpected opening for July 1, 1981 in fu
approved four year program in large commu
ity teaching hospital in Detroit. Write or ca
Dept. of Health Education, Saint John Hospit
22101 Moross Rd., Detroit, MI 48236. (31
343-3875.

FAMILY PHYSICIAN to assume well esta
lished family medical practice in a pleasa
thriving community on Lake Michigan. Plen
ful outdoor recreation, near colleges. 120 b
hospital, excellent consulting specialists. Co
tact Frank L. Groat, MD, 631 Franklin, Grar
Haven, Michigan, 49417. Phone 616-842-81
or 842-6126. Relocating soon to a warmer c
mate.

Ear, Nose and Throat practice available. E
tablished for the last 40 years. Located
Southfield, Michigan, in medical building adj
cent to hospital in prime medical/commerci
area. Excellent opportunity for new practitio
er, or for established surgeon to expand ov
practice. For information call (313) 569-6569.

PEDIATRIC RESIDENCY — Grad Year II
Unexpected opening for July 1, 1981, in ful
approved three year program in large cor
munity teaching hospital in Detroit. Write
call Dept. of Health Education, St. John Hosp
tal, 22101 Moross Rd., Detroit, MI 48236. (31
343-3875.

(Medical) Specialist — Ob/Gyn or Othe
Grosse Pointe Area, five room suite. Other te
ants are family practice clinic and radiologi
with ultrasound, fluoroscopy and nucle
medicine. Full maintenance with janitorial ser
ice. $500.00 per month. 16840 E. Warren
Steven at (313) 882-7060.

OB-GYN: Board eligible or certified to jo
busy practice in a beautiful resort area close
Detroit. Excellent office located one mile fro
hospital. No investment required. Equal wor
Salary open. Partnership available after first
year. M. I. Sabbagh, MD, P.O. Box 163, S
Clair, 48079. 313/329-7000.

PART-TIME PHYSICIAN needed to do routir
physicals to assess donor suitability f
plasmapheresis. Good position for old
physician looking to slow down. Malpracti
coverage provided. Contact Thomas Andersc
at American Plasma Management, Kalamazo
MI. Phone 616/381-0086.

Ob/Gyn practice open in Mt. Clemens are
Present incumbent retiring when suitabl
qualified applicant applies to take over offic
Write O.W. Oughtred, MD, F.A.C.O.G., 359
South Gratiot, Mt. Clemens, 48043.

Positions open

Primary Care Physicians for independent fam
ily practice, internal medicine, and pediatrics
North Central Wisconsin. Excellent clinica
facilities and assured support of independen
practitioners. P.O. Box 801, Neenah, Wiscon
sin, 54956.

Positions With The State Of Michigan — Cur
rently taking applications for positions ex
pected to be available in the future. Primaril
interested in board certified or board eligibl
internists with cardiology background. Offic
locations in Southfield, Lansing, and Travers

ty. Also considering an office in Kalamazoo. lary in 50's with approximately 40% fringe nefits. An equal opportunity employer. All quiries treated confidentially. For further deils please write: Disability Determination ervice, P.O. Box 30011, Lansing, MI 48909, or ll collect: Harry D. Nesmith, MD, Chief Medil Consultant (517) 373-7830. In Michigan, call ll free 1-800-292-2710.

ositions wanted

rologic Surgeon seeks practice opportunity West Michigan, solo or group. University ained, board certified, 5 yrs. solo practice. reviously board certified anesthesiologist. nerican, University of Michigan graduate 959, christian, married 24 yrs., 5 children. ichard M. Delnay, MD, 1646 Sam Houston Dr., arlingen, TX 78550.

iscellaneous

OR LEASE — Office of former busy general actice now occupied by mental health group. 80 sq. ft., four exam rooms, private office, ray room, in Romulus, Mich. Available in ebruary, 1981. Option to buy, with dental inic already leased in same building. Call 13/761-3465 days or evenings.

LORIDA SUNCOAST VACATION CONDO. Deht in the sunsets from your balcony on the ulf of Mexico. Luxurious 2 bedroom, 2 bath ondo on beautiful Indian Rocks Beach. Cenally located, convenient to Disney World, ampa, St. Petersburg and Clearwater. There private covered parking. Completely furshed with wall to wall carpet. An all electric tchen, micro-wave oven, dishwater, washer nd dryer. Cable colored T.V. and a fireplace in e living room. Sorry, no pets. Prices — 400.00-weekly, $1500.00-monthly, and 1400.00-annually. Contact Sue, 813-586-3751 on.-Fri. 9-5. 813-360-1131 Nites-Weekends.

RONWOOD, MICHIGAN (U.P.) — 1½ story 2 edroom house on 20 acres of partially ooded land. 1½ baths, new double roof, new opper/PVC plumbing, new combo storms upairs, new exterior caulking and paint. Large auna, woodshed, 2 car garage with large ork/storage space. Includes 2 refrigerators, est freezer and stove. Wood/oil heat. Only inutes from all the ski slopes. Excellent ski/ immer house. $39,900 firm. Call (906) 932-797, after 5 p.m.

AKEFRONT HOME. Southern Jackson ounty. 175 feet of water frontage. Year ound home with four large bedrooms, two ll all-ceramic tile baths with vanities. Approxnately 2300 sq. ft. of living area. Expressway riving time to Wayne State Medical Center in etroit — 1 hr. 30 min.; to University of Michian Medical Center in Ann Arbor — 30 mintes. Write Owner, 23202 S. Brookside Dr., Dearorn Heights, MI 48125.

AX SHELTER — Let us show you how your fice equipment, furnishings, or library can be onverted to a conservative tax shelter which ill double your true investment in six years. e are a physician owned company with expeence in meeting the financial needs of physians and other professionals. Call us first for gnature loans. Fast, confidential service. ri-City Capital, Inc., 1420 Center Avenue, Bay ity, Michigan 48706. 517/894-2051.

l. Clair Michigan — Modern medical office, near hospital, 1200 sq. ft., available January 1981. Good growth location and pleasant living. Ample parking. Reasonable rent. Call M. I. Sabbagh, MD, 1-313-329-7000.

Howell, Michigan — 8,000 sq. ft., medical-dental, available January, 1981, in attractively designed professional building. Complex conveniently located within walking distance of hospital which serves fastest growing county in state. For information, call evenings, 517/546-8895.

OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury, two & three bedroom units. Near Boyne ski hills. $92,000-$96,500. Furnished unit rentals available for vacation year round. A.K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

St. Thomas, U.S.V.I. Ocean front condominium villa. Sleeps 4-6. Three pools, free tennis, duty free shopping. List of local medical meetings available. Reduced air fares. 313/543-2970 or 542-7600.

Hilton Head Island, SC. Ocean Villa, Captain's Cove in Palmetto Dunes Resort. Luxurious new villa, 150 yds. from beach. Lagoon backyard, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, pool, fishing, canoeing, biking, etc. Weekly, monthly. Call or write, 313/695-0356, 6236 Kings Crown Rd., Grand Blanc, MI 48439.

We have various quantities of medical equipment available in excellent condition. We buy, sell, trade, move. New equipment also available. Call Doctor Medical Resale, 313-569-4407, 9 am to 9 pm.

MSMS/A

Shape up for life!

By Barbara Grennan, Muskegon

Are you overweight? Out of shape? In need of some direction to correct these deficiencies?

These questions are being answered by medical society auxiliary efforts in behalf of the American Medical Association Auxiliary's national "Shape Up for Life" campaign. Posters, pamphlets, buttons, T-shirt transfers and public service announcements (all available from the AMA Auxiliary office in Chicago) are being used all over the country, as auxilians promote this great health program.

This is the second year of effort by the AMA Auxiliary and the MSMS Auxiliary to interest people in getting and staying fit. A continuing program which emphasized nutrition its first year and physical fitness this year, it will zero in on mental health and stress in its third year. With over 50 million obese people in the USA, encouragement is needed from health care providers and their spouses to challenge the general public and themselves to improve their self-images.

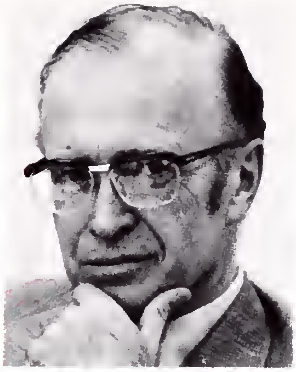
As auxilians, we are involved in many other areas of health care support programs. Individual counties have projects uniquely their own.

We also have educational package programs available from the national auxiliary which are supplied on request. Their subjects include drug abuse, smoking, hypertension, alcohol, blood donors, focus on kids, health education, health manpower, mental health, services to aging and venereal disease.

In addition, we have a great resource in our Project Bank Catalog, which is a compilation of projects, programs and ideas tried and proved by auxilians all over the country. Several of the projects in the bank originated with Michigan county auxiliaries and we are proud of their contributions to this national resource file.

We are involved, but stand ready to be more active if we can assist MSMS in any way.

Mrs. Grennan is MSMS/A president-elect and chairman of Health Projects and Project Bank.



My goal: forging formal links with groups which share our destiny

By John R. Ylvisaker, MD, MSMS President

In my view, organized medicine has two primary purposes:

1) Advancing the art and science of medicine, and

2) Constantly assuring an environment in which the art and science of medicine can serve the public most effectively.

I am frequently challenged by "What is MSMS doing about . . . ?" or "Why doesn't the Society . . . ?" or, more critically, "Organized medicine is only concerned about the doctor's pocketbook!" Such questions force me to measure every MSMS activity, goal, and strategy by the yardstick of these two purposes.

"Advancing the art and science of medicine" is a purpose so clear and so natural that any consonant activity is easily evaluated or justified by its measure.

The second major purpose, "securing a favorable environment for the practice of medicine," is by far the more difficult yardstick to apply. Under the umbrella of this purpose, selected MSMS activities may be justified by some but strongly criticized by others. The judgment call rests on whether the activity is viewed as mainly self-serving or is truly aimed at providing physicians with the freedom, knowledge, facilities, or "means" to make sound medical care available.

Regardless, this second purpose requires that MSMS aggressively engage political, economic, social, ethical and professional issues affecting medicine. I believe it also requires our involvement to be judged by whether it truly betters public care or perhaps more realistically, favors physicians.

Having objectively applied the above yardsticks to potential MSMS involvement in the issues faced by medicine, it is my conviction that MSMS can effectively engage issues only by forging links with major groups which either share our destinies or are dominant vector forces in Michigan health care.

Our greatest asset is our knowledge of how the health care system functions. Our greatest strength lies in how effectively we use that knowledge and, by intelligent persuasion, succeed in gaining the support of "numbers" for our positions.

One of my major goals therefore has been to promote or establish links which can enhance the ability of MSMS to affect our practice environment positively. As a brief report, let me outline the more important of these:

1. **Medical specialty societies** — These groupings of MSMS members have not had an effective common forum or communication bridge. A committee of their presidents with a voice on the Council has now been authorized and a greater voice at the House of Delegates is being recommended by Doctor Siegel.

2. **Hospital medical staffs** — Medical staffs are the centers of the clinical lives of almost 100 percent of our members. No linkage has existed. A task force recommendation is under review for a "medical staff support center" and a "council" of medical staff presidents.

3. **Medical school faculties** — These are the "shepherds" both of scientific knowledge and of our young physicians. No formal linkage exists and there is little sharing. A task force is presently developing a plan for an effective tie.

4. **Medical students and resident physicians** — MSMS already is carrying out Docto Baumann's committee recommendation to bring in this futur generation of physicians.

5. **The Board of Medicine** — A new system of physician an staff monitoring has been instituted for a stronger link wit Board function.

6. **The Department of Publi Health** — Strong MSMS suppor and interaction is stressed at al levels in recognition of the official responsibility of the department for the public health.

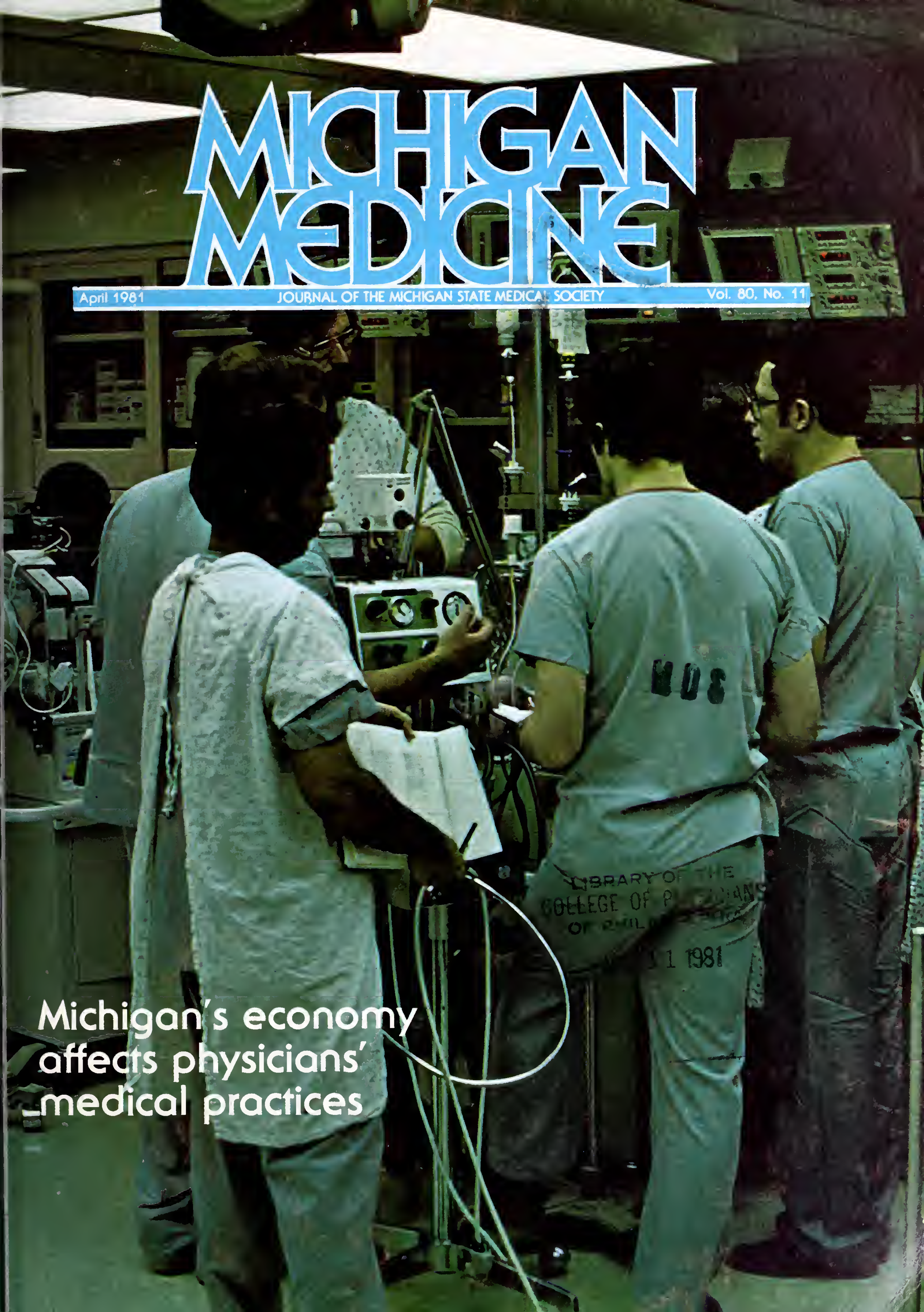
7. **Michigan Hospital Association** — Because of the obvious commonality of environmen and purpose, a most importan new link has now been formall instituted to provide leadership-to-leadership interactions on al issues of mutual concern.

8. **Third party payors** — Although formal relationships cannot exist, communication is essential to mediate problems o both sides. A "Third Party Payo Advisory Committee" has bee recommended for House of Delegates action.

9. **Entities affecting healt care economics** — No mechanism has ever existed for providers to sit as equal partners wit labor, industry, insurers, an government as decisions are made affecting our professiona lives. A provider-initiated "healt care economics" coalition is bein formed to address the economic of health care.

MICHIGAN MEDICINE

April 1981
JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY
Vol. 80, No. 11



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
1 1981

Michigan's economy affects physicians' medical practices

Do you know

a physician
with problems
of alcoholism,
drug abuse,
or other
difficulties
which interfere with
his/her abilities
to practice medicine?

If so, please contact
your MSMS Impaired Physicians
Program through Marce Ireland
at MSMS headquarters
(517) 337-1351.

MICHIGAN STATE MEDICAL SOCIETY
1866

MSMS serves physicians in many ways

MSMS represents you and your colleagues in public health and welfare programs.

MSMS interprets you — your training, your motives, your problems, your professional aims and objectives — to your community.

MSMS tries to nurture a favorable public concern toward your profession by helping people to understand and appreciate medicine's contribution.

MSMS guides the development of medical practice in relation to other callings and economic groups.

MSMS protects your legal status as a doctor.

MSMS helps keep medical competition on a professional plane.

MSMS helps your profession to meet its collective responsibilities to the public and avoids the necessity of the public resorting to political devices to solve these problems.

MSMS regularly offers outstanding continuing medical education programs to keep you abreast of the latest and most effective medical theories and techniques.

MSMS provides for you those personal benefits, services, and representations impossible to secure and maintain as an individual.

MSMS helps you to survive and have your voice heard as a responsible professional in an increasingly interdependent and socialized society.

MICHIGAN MEDICINE

Michigan's highly refined, organized and technical medical care system is coming up against Michigan's shrinking economy. This month's special report discusses some of the collision points. **Photo by Mert Scholten.**

MICHIGAN MEDICINE

April 1981, Volume 80, Number 11

Special report

149 Michigan physicians are sharing in a significant way in the woes of the state's difficult economic times. This month's special section explores the variety of ways in which this is so, particularly in the ways the state's budget slashes affect medical practices; Jay Harness, MD; Judith Marr, Charles L. Downs

Features

154 A major AMA report on marijuana and its recreational and therapeutic uses

163 Tear-out reference card by the American Cancer Society, Michigan Branch, on the Pap Smear

165 New, competitive reimbursement systems put medical cost, use decisions at local level; David Raymond and Fred Patterson, MD

172 Legislative profile: Mary Keith Ballentine; Willah Weddon

180 The Michigan hospice MD; Eileen McMahon

185 Borgess Hospital has outstanding cardiac rehabilitation program; Martha Boyce

188 Growing use of industrial solvent something to watch; Kim White

Departments

144 In my opinion; Charles L. Oppy, MD

145 Letters

148 MSMS/A; Donna Chase

152 Ad index

168 Views; Robert E. Medlar, MD

175 New members

182 Medical newsfronts

192 Meetings

197 Category I meetings

200 Deaths

202 Classified

204 President's page; John R. Ylvisaker, MD

IN MY OPINION

As numbers of MDs increase, they'll go where needed

By Charles L. Oppy, MD, Roscommon

Depending upon which government release you read and from which department it is released, the number of physicians in the United States is either excessive of insufficient. New medical schools and enlarged, existing medical schools are producing increasing numbers of physicians. Yet we hear of areas in Michigan as well as other states which are markedly undermanned by the medical profession.

The question of whether this is a problem of actual shortage or one of maldistribution is argued endlessly. There is really no doubt about the problem of distribution in areas of our northern lower peninsula and the upper peninsula.

Efforts to entice new, young practitioners to these medically deprived areas now involve groups of people armed with government grants and the government proposal to forgive student loans if time is spent in the area where care is needed by the people. Some degree of success is seen in this activity. However, physicians being the rugged individualists they generally are do not take easily to being assigned to certain restricted areas of the country for a period of time.

It would seem that the growing number of doctors available and the law of supply and demand in the medical marketplace will ultimately solve this dilemma. Medical schools are now taking more students who are oriented to rural practice areas, and who are more apt to return to such areas to live and practice following graduation.

The practice of family medicine is not looked upon as, somehow, less of an accomplishment than practice of a specialty, and more students seem attracted toward primary care than a few years ago. The attractiveness of primary care situations in rural areas and small towns should be emphasized more fully in recruiting medical practitioners. Doctors should practice in an environment which is agreeable and where they are happy.

The other factor working in favor of solutions to the long-standing problem is that as numbers of doctors increase, they will go where they can best be useful, and therefore successful. Distance from a medical center need not be a prohibitive factor in a successful practice. It is not necessary to have immediate access to a CAT scanner in order to practice good medicine. The basic tools such as stethoscope, blood pressure cuff and ophthalmoscope still work, and produce good medical evidence of the presence or absence of disease. Access to excellent, small hospitals is available in most areas even though they are a few miles away. Distance is not the factor in rural areas that it is in urban locations. Schools are good, and happily, crime is much less a factor than in the densely-populated areas.

These attractions will ultimately bring more physicians to the regions and solve our problem without bureaucratic fiat.

Doctor Oppy is a member of the MSMS Committee on Publications, and an MSMS councilor. He also is chairman, MSMS Legislative Policy Committee.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
James H. Tisdel, MD, Port Huron, Chairman
Busharat Ahmad, MD, Marquette
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $20.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. ©1981 Michigan State Medical Society.

18 66

LETTERS

Doctors and nurses

H.M. Andre, MD, *(In My Opinion, Michigan Medicine*, Nov. 1980), quotes Patricia Harris, then Secretary of Health and Human Services, as saying that by 1990 this country will have 70,000 excess doctors of medicine. Doctor Andre then uses this excess in one profession (medicine) to rationalize an attack on another profession's (nursing) right to determine the level of education it will require of its practitioners. It seems strange that Doctor Andre would attack the nursing profession's right to determine that the baccalaureate level will be minimum preparation for its practitioners while at the same time seeming to indicate pride in the fact that medicine has such extensive preparation.

The medical profession recognized and responded to a need to change the level and quality of education of its practitioners following the Flexner report. As the scope of nursing practice has changed in response to the more complex health care needs of society, so must the level of education for entry into professional nursing practice change. The need for graduate level preparation in nursing has been well documented. The bachelor of science degree in nursing provides a sound basis for this much-needed advanced preparation.

Many citizens need the quality of health care and nursing care which can and is being provided by the many well-educated professional nurses in Michigan. This is not second rate medical care as suggested by Doctor Andre, but rather first-rate nursing and *health* care appropriate to the patient situation.

The conclusion made by Doctor Andre is that "We do not need bachelor degree nurses to practice medicine." Unless Doctor Andre possesses some unstated knowledge of the level of nursing education needed to practice nursing, I suggest that neither nursing nor the citizens of Michigan need physicians to dictate what that level of education needs to be.

Regina M. Williams, RN, MSN
Assistant Professor of Nursing
Wayne State University College of Nursing
Detroit

The Governor writes Doctor Siegel

The following letter was received Feb. 20 at MSMS headquarters by David Siegel, MD, immediate past chairman, MSMS Medicaid Liaison Committee.

I would like to take this opportunity to extend my personal gratitude for your contributions over the past several years as chairman of the Michigan State Medical Society Medicaid Liaison Committee.

The untiring dedication you brought to the liaison role has been appreciated by all involved. You have made many contributions to the Medicaid program in fostering a better understanding of the physician's role. Conversely, physicians in Michigan have gained a far better understanding of the Medicaid program due to your efforts.

You and I have had several honest exchanges about Medicaid, and your candor and sincerity leave a lasting impression. Your ability to articulate a position, both eloquently and succinctly, is well recognized. While our discussions have usually centered around the physician's involvement in the Medicaid program, it has always been evident that your foremost concern is for the patient. You are to be commended.

The fact that physician participation in the Medicaid program has been at its zenith during your tenure has made your role one of increasing significance. In reflecting over the past nine years, I would like to personally acknowledge your work in averting crises, assisting in program changes, and identifying solutions to issues involving both the Medicaid program and the physician community.

William G. Milliken
Governor

Correction

For those readers who might wish to contact the principals in the February, 1981 *Michigan Medicine* article, "How to be a better expert witness," we publish the following corrected name and address:

Daniel A. Bronstein, LLB, LLM, SJD, Associate Professor
Department of Psychiatry
Michigan State University
East Lansing, 48824
(517) 353-5326

MD
Reamer Keller

"He said his recovery was a miracle, so he sent the check to the church instead of to you!"

Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ⒸIV, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® Ⓘⓥ
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient
Contraindicated: Known hypersensitivity to the drug Children under 6 months of age Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy, gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy
Dosage: Individualize for maximum beneficial effect *Adults* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b i d to q i d , alcoholism, 10 mg t i d or q i d in first 24 hours, then 5 mg t i d or q i d as needed adjunctively in skeletal muscle spasm, 2 to 10 mg t i d or q i d , adjunctively in convulsive disorders, 2 to 10 mg b i d to q i d *Geriatric or debilitated patients* 2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (See Precautions) *Children* 1 to 2½ mg t i d or q i d initially, increasing as needed and tolerated (not for use under 6 months)
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10 Prescription Paks of 50, available in trays of 10

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

MSMS/A

Auxiliary a part of the MSMS impaired physician team

By Mrs. R. Jack Chase, Grand Rapids

As the spouses of physicians we are probably in the best position to recognize the trouble spots of stress, over-work, alcohol and drug abuse.

Yet what do we do? Sometimes we close our eyes to the situation, thinking it can't happen to our family, or wonder where to turn for help.

As a part of the MSMS Auxiliary, we have a place to seek help before the family is devastated. Perhaps the trouble spot is with us, the spouse. It is difficult to cope with the stresses of a young family, long hours alone or the social problems of the mature years.

The MSMS Impaired Physician Program is prepared to help both the physician and spouse recognize the problem and by the services of this program work through to a beneficial solution for all.

The Auxiliary will take an active role in promoting these services. As the first step of this program the Auxiliary will show the film, "Our Brother's Keeper," at the annual convention April 28-29, at the Marriott Inn, Grand Rapids. By presenting this audio-visual aid to state and local auxiliary leaders at convention we hope to bring about an awareness of the seriousness of the problem. This program will be available for use at county auxiliary meetings.

Members can be educated by the use of this film and other promotional training programs of MSMS. Contact Marce Ireland at MSMS headquarters for further information regarding this film.

To be informed is to understand and, ideally, to accept the help provided by the Impaired Physician Program. The auxiliary and the county medical society can work together to develop a program on the local level. Concern and caring at this point will strengthen the family unit.

Mrs. Chase is president, MSMS Auxiliary.

Michigan's depressed economy hurting medical practice in several ways

By Jay Harness, MD, Chelsea

Michigan, as we all know, is in the midst of hard economic times.

Each Michigan physician is grappling on an individual basis with the economic squeeze. I would like to discuss the two major ways I feel physicians are affected most by the economic situation, and a third factor compounding the problems.

The economic downturn in Michigan has caused a reordering of the financing of health care. One of the biggest impacts of the downturn is on our social welfare programs. There are fewer public dollars available for the Medicaid program, mental health care, disability payments, hospitals and treatment regimens.

Medicaid affected

Clearly, there is a decrease in what the state is willing to pay physicians in Medicaid dollars (see related article in this section). Exacerbating problems of physicians and Medicaid patients is inflation, which affects the operational costs of practice. A 10 percent decrease in Medicaid dollars actually can be as much as a 22 percent decrease in real revenues when the factor of inflation is included. So the whole thing is substantial.

The impact of fewer Medicaid dollars for physician reimbursement varies all over the state. It probably is not as great for the physician in areas not solely dependent on heavy manufacturing as it is for the inner-city Detroit MD who may have as many as 70 percent of patients receiving medical care through Medicaid.

Some physicians are able to talk about mixing patients with private and public reimbursement programs to maintain a steady income, but many Michigan physicians with a high percentage of Medicaid patients don't have this luxury.

Insured people

The poor state of the economy definitely has had a second major impact — on the numbers of people with health insurance. The numbers either are remaining static, or are decreasing, particularly in the Detroit area.

As working people are laid off indefinitely, their unemployment benefits give out, including their health insurance coverage. Professional and provider groups, including the Greater Detroit Area Hospital Council and the Wayne County Medical Society, already are trying actively to grapple with the problem.

This obviously decreases the working population's abilities to seek medical attention and to pay for it.

Paradoxically, but understandably, there is a boom situation currently in public-supported facilities and programs serving the poor, such as Wayne County General Hospital.

WCGH is a public institution and the largest provider of care to the indigent in the Detroit area. Individuals having lost their insurance are turning to Medicaid and, as a result, are showing up on the hospital doorstep to receive care.

In economically hard times it's the public institutions which become busier.

The situation will continue to deteriorate, because, given all the economic pressures everyone is under, industry, especially the Big Three auto companies, is trying to cut costs.

It is reported the average auto worker, through salary and fringe benefits, makes $19 an hour. With auto companies' costs so high, they are becoming noncompetitive. The point is, the auto companies are looking at ways to cut back their dollar outlays.

One of the ways they will cut back surely is in their health care expenditures for employees. There obviously will be a ripple effect out to practicing physicians.

Part of the cuts might be made in such programs as vision care. But the automakers' health care expenditures may decrease in first dollar coverage, as they will look at many ways to cut their overhead.

Compounding factor

The compounding factor mentioned early in this article is the predicted increase in number of physicians giving care. Should an oversupply of physicians indeed develop, physicians may be fiercely competing for patients. Physicians may have to band together to get patients, and to sit down with the people who can enter into contracts with MDs as groups to provide medical care — the HMOs and IPAs.

Increasing numbers of HMOs and IPAs will be delivering health care in Michigan.

Physicians will be increasingly interested in HMOs and IPAs in order for them to at least guarantee a base income for themselves.

In addition, Medicaid may well be going to established HMOs and paying a fixed budgeted amount per person to provide care.

I think physicians are going to have to look hard at how they are doing business to become more competitive. Historically, we could just open the door and patients would come in. Things aren't like that any more.

Doctor Harness is chairman, Advisory Committee to MSMS Bureau of Economics.

State's budget woes felt here

By Judith Marr, Editor

Paul Allen, Director
Medical Services Administration
Department of Social Services

Michigan will increase its support of the state Medicaid budget (half of the Medicaid funds are made up by federal funds) a bit in 1982. But the approximately five percent increase in state funds is very small, with inflation in double digits and as high as 15 to 18 percent in health care, says Medical Services Administration Director Paul Allen. "The amount of money for 1982 actually is going to be less in terms of deflated dollars."

The state's share of the Medicaid budget for fiscal year 1982 has been proposed by the governor at $1.221 billion, up $61 million from the FY '81 budget of $1.160 billion.

"The Medicaid budget is a big 37 percent of the Department of Social Services budget. And the amount spent on health services by the state government constitutes the largest single budget in the state — bigger than ADC, education, than anything. So it's very much in the spotlight," Mr. Allen observes.

Hearings scheduled for late February and March by Rep. David Hollister, chairman, House Appropriations Committee's Subcommittee on Social Services, probably would not change the Medicaid appropriation much, predicted Mr. Allen as this article was being prepared.

Special interest groups testifying at the hearings might rearrange how the money is spent, he said, but not the bottom line of how much is spent.

"One of the serious problems in the Medicaid budget is physicians' fees, which are considerably below where they should be, based on inflation and past years' levels," he acknowledged.

"The new Medicaid budget is not going to do more than restore physicians' fees to where they were on Dec. 1, 1980, and will still leave them 30 to 40 percent below upper Medicare payment levels.

"We don't like it at all, but given the fiscal facts in this state, we had to parcel out the money."

Mr. Allen estimates over 1.1 million Michigan residents will be on Medicaid at some time during 1981, and that 14 percent of the state's population is on some form of public assistance.

"It seems we just can't go any higher," says Mr. Allen.

In early February he warned, however, the projected DSS budget could be as short as $40 million if caseloads go higher.

"We're optimistic that the economy will improve a little bit, and that caseloads will at least stop growing, if not decline a bit. We hope so, because great pains have been taken to be sure health is given its share of dollars."

The Reagan administration's plans to cut Medicaid appropriations substantially don't shock Mr. Allen. "Our analysis says that our activity and that at the national level happen to coincide. We're on the same track and conceivably could live with Reagan's approach, providing the formula for allocating federal funds to the states, as we understand it, is adhered to."

Mr. Allen says he and DSS Director John Dempsey are hoping federal funds are given to the states in block grants, as Reagan people have hinted, rather than caps placed on expenditures.

"The block approach gives us more flexibility. You know how much money you can depend upon. Under a cap approach, if you don't happen to come up to the cap allowed, you cannot redistribute funds to related worthwhile activities."

Samuel I. Gershon, MD, Director
Lafayette Clinic

Physicians can get an idea of how state budget cuts are affecting medical research around the state from Detroit's Lafayette Clinic Director Samuel I. Gershon, MD: "I think it's almost devastating."

More than $1,000,000 in state assistance has been cut to the clinic. That is 12 to 15 percent of the clinic's total budget. One neurological ward and one adolescent ward, totalling 45 beds, have been eliminated from the clinic, and, at this writing, Doctor Gershon is afraid he would have to drop nine physicians from the staff.

"Although the state honestly intends to treat research activities as best it can," he reflects, "when you have such cuts to staff and facilities, you can't separate the two.

"When one goes down the chutes, it's difficult to maintain the other."

Letting those nine physicians go will leave no senior personnel on some wards, says the director of the reknowned psychiatric research facility.

And the real problem, he said, is that "after the flood is over, we're going to have problems restoring our programs. There have been problems here in the last several years in recruiting psychiatrists, anyway.

"We are going to try and meet with the legislators," he said, reporting that the clinic was sending invitational letters to legislators on Feb. 25. "But these budget decisions were made before we could get around to doing something about them."

Doctor Gershon declared that it's the public, the families of patients and their support groups, that could do the most to influence the legislature, however.

In addition, he suggested that by cutting the mental health budget, the state is creating its own burgeoning social services budget.

"You know, there are big cuts in mental health, but increased hiring in social services. It would be smarter to take the money creating the extra social services budget and put it back into mental health."

Doctor Gershon's appointment a year ago, as Lafayette Clinic director became a cause celébre for a time, due to technical questions about his Michigan medical licensure qualifications. The Board of Medicine finally issued him a "Clinical academic license," allowing the distinguished psychiatrist, an internally recognized expert on psychopharmacology, to head the research center.

How does he feel in his new post, with such major budget difficulties facing him? "Sadly," he says.

awrence Weiner, MD,
nterim Dean
Wayne State University
School of Medicine

Wayne State University has required its School of Mediine to lay off non-tenured faculty efective July 1 "to the tune of $1.1 milion worth," according to Interim ean Lawrence Weiner, MD.

Letters of notice have gone to 27 on-tenured faculty members, he ays. "We've tried to be selective in ur layoffs to the extent we could, so hat the layoffs have a minimum efect upon our programs. We will easure the impact if and when hose persons disappear from our faulty."

Those faculty members are "not ery happy about it," says Doctor Veiner, "but they have to accept the ict the state is in tough shape. And ey, too, must bear the effects of a oor economy.

"But they have gone along with ll of our necessary measures. And ere is an optimistic feeling that we ave been there before, come back, nd we will come back again."

WSU's School of Medicine made ther cuts during recent months, "in e usual belt-tightening ways, to the ne of $500,000," he continues.

For instance, during the past two ears, the medical school has witched all research personnel off tate funds and onto non-state funds, ghtened up on purchasing and relacement of equipment, nearly liminated travel reimbursement, and ut supplies down to the bare essenals.

As interim dean, Doctor Weiner as been responsible to implement e edicts of the central university dministration in a way least harmful the medical school.

"After being involved with this chool for 30 years, I've lived rough many periods like this, ough none so severe.

"Thus far, we have been able to aintain the quality of the school. Ve are hoping, however, that much ooner than later we will get some reef so we can go about the business f creating better programs and imroving our stature."

John A. Gronvall, MD, Dean
University of Michigan Medical School

The University of Michigan Medical School is taking a three-pronged approach to the drop in budget funds for the coming year.

First, it is considering reducing numbers of faculty members. Second, the faculty are searching for other and new sources of financial support. Third, the school will review programs for possible reduction and/or elimination.

U-M Medical School Dean John A. Gronvall, MD, believes the Reagan administration's budget at best will simply hold the line on research funds, if not reduce them, and that it will soon eliminate all capitation grant programs for education.

If the latter occurs, U-M would lose $700,000 in federal funds, he reports. If student aid also is cut by the federal government, he predicts problems particularly in recruiting minority and disadvantaged students.

The Medical School already has eliminated six to eight basic science faculty positions over the past two-three years, and might continue to do so as federal and state funds drop.

The medical school also is seriously considering placing its 132-plus basic science faculty on nine-month, rather than 12-month appointments. This would reduce the university's support of those faculty members by 18 percent, which basic science faculty would be forced to make up through research grants, or other sources of funds.

How does Dean Gronvall feel about reductions in funding support for his medical school?

"My biggest single point is that strong, continuing federal support for basic research is important, because it is a very long-term investment which makes a big difference in the quality and progress of our lives.

"But I know enough about the problems of federal and state government to know when they don't have the money to pass out, they have to make decisions.

"On another level, gaining control over inflation in this country is really extraordinarily important. If medical schools kept getting money and our country went broke, that would be no good."

W. Donald Weston, MD, Dean
Michigan State University
College of Human Medicine

Michigan State University's College of Human Medicine is perhaps further along in specifics of budget reductions than are the state's other two medical schools, observes Dean W. Donald Weston, MD.

"And the closer you get to specifics, the more intense the feelings get," he continues.

MSU's budget cutting proposals, including the outright closing of several colleges, have received considerable publicity in recent weeks as supporters of each program proposed for cutting have protested loudly.

Dean Weston calls the MSU College of Human Medicine's late 1980-early 1981 budget-cutting exercises "a learning experience I hope I don't ever have to go through again."

MSU President M. Cecil Mackey on March 23 announced his final proposals for university-wide budget cuts. Two weeks of hearings were to continue, with the Board of Trustees expected to make final decisions by April 3.

President Mackey, in an introductory statement to preliminary proposals, included the College of Human Medicine among those given highest priority for continued funding.

President Mackey gave priority to those colleges which "contribute to the mission of Michigan State University by instruction, research and public service." They also were perceived, he explained, as serving all levels of students, both sexes, minorities and others through both traditional and non-traditional means.

Preliminary proposals were for the College of Human Medicine to have its budget slashed a maximum of $1,366,861. This places the college 15th of 22 academic programs in amounts to be cut.

Dean Weston said the college's budget proposals do not call for any MD faculty members to be laid off, and that class sizes would be maintained at their present 105 students.

"I think we are able to maintain our uniqueness," he said. "We still are in a strong position."

U-M economist paints dim picture of state's medical care economics

By Charles R. Downs, special to Michigan Medicine

The picture I have painted is not very bright," said the speaker, as his audience laughed ruefully. He was describing the economics of medical care in Michigan. The occasion was the MSMS Auxiliary's annual Legislative Day in Lansing. The speaker was Paul Feldstein, PhD, professor of public health and economics at the University of Michigan.

Demand dropping

Demand for medical services is dropping because of inflation and unemployment, especially in Michigan, said Doctor Feldstein.

Less demand, he continued, plus increases in physician supply, plus cost-containment policies on the part of federal and state government, health insurers, industry and labor all add up to less income per physician.

The federal government, he said, created demand when it enacted Medicare and Medicaid in the 1960s.

Similarly, economic factors in the 1960s greatly stimulated demand, the speaker explained. As personal income grew, medical expenditures grew. Tax laws encouraged the rise of health insurance as a nontaxable fringe benefit, and further increased demand.

Now, both labor and business, he continued, have become concerned about the increasing costs of health care because it adds to the cost of automobiles and other products. So, they too, along with the health insurance companies, are trying to contain costs.

No federal relief

The current federal administration does not promise any relief for medical care providers, noted the U of M health economist.

"President Reagan," he said "is not going to propose anything in the way of health-care programs that will increase government costs."

Rather, President Reagan would like to cut Medicaid costs by imposing an expenditure limit. Also, he is suggesting tax-law changes which would permit taxing of fringe benefits above a set amount, according to Professor Feldstein.

On the supply side, the speaker pointed out, the federal government has funded programs to increase the number of medical schools and the number of students at each. More physicians and less demand mean that the number of physician visits are going down, he added.

One result is that HMOs (health maintenance organizations) are finding it easier to attract new physicians, who might otherwise have difficulty starting a private practice.

Another supply factor, he said, is a trend toward substitutes for physicians' services by chiropractors, optometrists, and podiatrists. He said that disputes over territory are increasing.

Increased supply, he continued, has contributed to greater competition for hospital privileges, leading to legal battles and conflicts among physicians.

Professor Feldstein said HMOs are an attempt to cut down health care costs. Their rise, he added, is putting pressure on fee-for-service physicians who, in turn, are forming their own HMOs in order to compete.

Regulation and competition

The speaker noted that two basic options are available — regulation and the competitive system.

Regulation would mean political control over how much money is spent on health care and how that money would be allocated. The government may be generous at first, he noted. But it would not be so later on.

And, even though the present federal government is opposed to regulation, it could happen at the state level.

Professor Feldstein said he personally favors a competitive system but one with greater incentive to reduce costs.

Growth of HMOs, he maintained, is helping to make the system more competitive. But he warned that there are risks in cost-sharing that could have drastic effects on the income of participating physicians.

One benefit of competition will be greater movement of physicians to rural and inner-city areas, according to Professor Feldstein.

Thanks to our Advertisers

Ad Council	196
Advance Medical Research Center	199
Brown Pharmaceutical	153
Burroughs Wellcome	184
Carlton Numismatics	197
CRT Management	191
Detroit Bank & Trust	181
Emergency Consultants, Inc.	198
I. C. System	169
Kent Community Hospital	199
Eli Lilly	167
Marion Labs	155
Marshfield Clinic	176
Medical Protective	192
East Lansing Orthopedic Assoc.	203
Michigan Cancer Foundation	175
Michigan Physicians Mutual Liability Co.	170, 171
ParaData of Michigan	189
Pennwalt Pharmaceutical	159, 160, 161, 162
Physicians Insurance Company of Michigan	187
Purepac	177
Roche	146, 147, 148, 173, IBC, BC
Sequoia Group, Inc.	183
Smith, Kline & French	193
Stratton Cheeseman	179
U.S. Air Force	186
U.S. Army	200
Upjohn Co.	174, 194, 195, 196
Wayne State University Medical School	201

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When
impotence
is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

AMA: "Perils and promise" of marijuana require continuing attention of medicine

The following article is presented in the spirit of MSMS House of Delegates Resolution 50-80A, which resolved: "That the MSMS through its official publications to physicians identify marijuana as a front-rank public health problem, and an agent of potentially severe adverse effect on individuals and on society."

This definitive report was presented at the December interim meeting of the AMA House of Delegates, San Francisco and was adopted as official AMA policy.

This report was developed for the AMA Council on Scientific Affairs by a special panel on drug abuse consisting of Joseph H. Skom, MD, Chicago, chairman; Henry Brill, MD, Brentwood, Long Island; Sidney Cohen, MD, Los Angeles; David E. Smith, MD, San Francisco; and Jokicni Takamine, MD, Los Angeles. Rogers J. Smith, MD, Portland, Oregon, chairman of the Council, participated as an ex-officio member of the panel.

It is perhaps ironic that, concomitant with emerging therapeutic possibilities for cannabis and its constituents, new evidence has appeared that marijuana is hazardous to health.

On the one hand, we are at the threshold of providing symptomatic relief to some patients who suffer extreme nausea from cancer chemotherapy and for whom existing antiemetic agents are ineffective. On the other hand, we face the growing prospect of an appreciable number of marijuana users incurring physiological and psychological impairment.

Marijuana is the drug of the young. More than two-thirds of 18 to 25 year old persons in the United States have tried it on at least one occasion. Some have been chronic users. For the children, adolescents and young adults who do smoke marijuana regularly there is considerable risk ahead. The risk for them, and for society, is of a nature and magnitude that belies the characterization of marijuana as a "soft drug." It can be hard on its user, and inflict a great deal of harm.

The AMA Council on Scientific Affairs has on two previous occasions called attention to the health aspects of marijuana use. In a report adopted by the AMA House of Delegates in December 1977 (Report D: I-77), the Council expressed concern over evidence of a range of adverse effects that had been appearing in the scientific literature. Two years later, in December 1979 (Report I: I-79), the Council reaffirmed its concern to the House, and emphasized in particular the dangers of pulmonary involvement and possible carcinogenesis. The Council also took cognizance of investigations into possible medical applications of marijuana, and urged that research be more rigorously designed and conducted in the future.

In adopting the second Council report, the House asked the Council to prepare a subsequent report on "(1) increased regular use of marijuana by youth, (2) the proliferation of the paraphernalia industry and so-called 'headshops,' and (3) the subverting of FDA laws and regulations by state laws that legalize marijuana use for medical purposes."

Then, in July 1980, the House referred to the Council Resolution 3, introduced by the Wisconsin delegation, proposing that, in view of growing evidence of health hazards, th AMA "officially declare marijuana t be a dangerous drug."

This report, which constitutes response to these requests, comes i the wake of three documents release earlier this year by the National Insti tute on Drug Abuse (NIDA): *Marijuana and Health: 1980*, HEW' eighth annual report to Congress: *Drug Retrospect: 1962 to 1980*; an *The National Survey on Drug Abuse 1979*. Taken together, these publications paint a disquieting picture of growing proportion of young peopl exposing themselves to dangers tha no longer are in the area of tenuou speculation.

Marijuana/youths

NIDA's latest national survey reflected significant changes in marijuana usage from 1971 to 1979.

In 1971, one of 10 adolescent aged 14 and 15 reported ever usin the drug. By 1979, the rate for thi age group had tripled, climbing to 3 percent. In the same period life-tim prevalence for 16 and 17 year old had risen from 27 percent to 51 pe cent.

Looking at the 12 to 17 year old who said in 1979 that they smoke marijuana on a fairly regular basis the survey showed that 8.4 percen reported using the drug on five o more days during the previou month. Over 22 percent of youn adults (18 to 25 years old) reporte this frequency of usage. These figures, based as they are on a survey households, undoubtedly are conse vative; it can be assumed that a sizable number of chronic users detac themselves from family settings, an that students living away from hom — who were not interviewed — might include a proportionatel larger number of regular users tha the surveyed population.

Although the NIDA survey indicated that only eight percent of 1 and 13 year old children in 1979 ha

continued on page 15

"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

PAVABID® AND PAVABID® HP
(papaverine hydrochloride)
150-mg Capsules 300-mg Capsulets

Patient benefit products from

PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY MO 64137

6/80

ever tried marijuana, this figure is a third larger than the percentage of children of that age in 1971 who said they had ever used it. Moreover, other surveys conducted in two states found a greater proportion of children than this who used marijuana. In 1978, one in five 8th graders questioned in Maryland said they were currently smoking marijuana, and one in 11 said they were doing so daily or several times a week. In Maine the same year, 56 percent of 13 to 15 year olds who were sampled said they had used the drug at least once, and 42 percent reported being regular users.

As pointed out in the two previous Council reports on marijuana, regular use constitutes a hazard for anyone; especially vulnerable, however, are children and adolescents, who are in crucial phases of psychological and physiological development. Additional findings of adverse effects of marijuana use in animals and humans, coupled with evidence of substantial regular use by young people, therefore have serious implications for the health of a new generation.

Some of the major recent findings as summarized in the 1980 Marijuana and Health Report that have particular relevance to youth can be grouped under the headings of brain function, psychomotor effects, reproductive function, pulmonary involvement, and psychopathology.

It should be emphasized that most deleterious effects are related to chronic or consistent, as opposed to episodic, use of marijuana. Metabolites of delta-9-tetrahydrocannabinol (THC) can be found in fatty tissue for up to eight days following intake, so that a cumulative build-up takes place with regular use. (THC is the most prominent psychoactive component of marijuana.) The quality of the marijuana is also significant; in this regard, it is noteworthy that cannabis preparations in use today are as much as five times as potent in THC content as those available five years ago.

Brain function

Conclusive evidence of macroscopic brain damage is lacking. Microscopic cellular changes, however, have been found in brains of rhesus monkeys who received the equivalent of one marijuana cigarette daily for six months. Similar measurements have not been made in humans.

Yet, the possibility that such changes, which may or may not be reversible can take place in man as well as in another primate cannot be dismissed out of hand. Moreover, damage does not necessarily have to be visible to result in impaired mental functioning.

In that regard, there are abundant anecdotal reports, if not controlled studies, on the lack of academic drive on the part of students who regularly use high doses of marijuana. Long-term sedative and other effects from chronic intake may combine with acute intoxication effects to initiate or to reinforce inattention to schoolwork or the wish to drop out.

The NIDA report alludes to "dozens of experimental studies" which consistently have shown adverse acute effects of marijuana use on cognition and immediate memory; so that for "substantial numbers of high school students (who) are using marijuana during the course of the school day . . . a detrimental effect on their classroom functioning and knowledge acquisition" is likely.

Psychomotor effects

The Council in its 1977 report on marijuana singled out motor vehicle crashes as potentially the most serious consequence of psychomotor impairment resulting from acute intoxication. Subsequent studies have indicated that as many as eight of 10 marijuana users sometimes drive when they are "high." NIDA predicts that "as use becomes increasingly common and socially acceptable and as the risk of arrest for simple possession decreases, more users are likely to risk driving while high."

A recent study in California, involving blood samples of 1,800 motorists arrested for driving while intoxicated, detected marijuana in 16 percent of the cases, nearly all of them in conjunction with the presence of alcohol.

The concomitant use of marijuana and alcohol, which is quite common, has its greatest implications in the area of highway safety. Reduction in reaction time, poor cognition and impaired coordination that have been observed with the use of either substance alone are markedly amplified when the two drugs are taken in combination.

Reproductive function

Possible disturbances in endocrine function of adolescents and young adults are of greatest interest insofar as they adversely affect sexuality and reproduction. In 1977, the evidence for such effects was sparse. Now, although inconclusive and often preliminary, there is a growing body of data from studies of chronic heavy use in animals and humans that point to diminished fertility and that substantiate danger to the fetus.

For males, there is conflicting evidence regarding the lowering of testosterone levels, especially as to whether such effects are long-term and attendant upon chronic use, or transitory as a result of acute administration. In either case, interesting research questions can be raised concerning aphrodisiac qualities of marijuana that have been alleged by some users. Reduced sperm counts, which were found in one controlled study, probably are not as significant for decreased fertility as are abnormalities in structure and impaired motility, also detected in sperm in this study.

For females, chronic marijuana use may cause abnormal menstruation, including failure to ovulate, and fetal damage. Menstrual problems were evident in a controlled study of street users in St. Louis, although concomitant use of alcohol by some of the subjects could have had some influence on the results. Experiments with rhesus monkeys have implicated THC as a disruptive influence on the reproductive system, with effects apparently mediated through inhibition of pituitary gonadotropin secretion, and also possibly through direct action on reproductive tissues. In another study, female monkeys treated with THC over a period of three to five years at levels comparable to daily human consumption of one or two marijuana cigarettes, suffered four times the incidence of fetal deaths, abortions and resorptions as did drug-free controls. Although demonstrable fetal effects have been largely embryocidal, the possibility of abnormal fetal development as a result of the mother smoking marijuana during pregnancy cannot be ruled out.

Pulmonary involvement

The two previous Council reports cited evidence of bronchial impairment and lung damage, including carcinogenic risks, associated with chronic and heavy marijuana smoking, and with combined marijuana and tobacco use. Additional supporting data come from a study done with rats who inhaled marijuana smoke daily for a period of one-eighth to one-half their life spans and suffered degenerative changes in their lungs more severe than those caused by cigarette tobacco.

Although the degree of comparability of marijuana and tobacco smoke in pulmonary effects is still debatable, one study of bronchoconstriction found that smoking less than one marijuana cigarette per day diminished vital capacity of the lungs as much as smoking 16 tobacco cigarettes. Because smoking several marijuana "joints" daily is not unusual among young people, their risk of incurring pulmonary problems may be far greater than that of heavy users of tobacco. The combination of tobacco and marijuana smoking, a common practice, is probably additive in its pulmonary side effects.

The 1979 Council report also dealt with the issue of spraying marijuana crops with paraquat, a herbicide found to have possible toxic pulmonary effects, although no evidence of paraquat toxicity in humans from smoked marijuana has been noted. This spraying reportedly has been discontinued; nevertheless, t would be advisable, in any future consideration of applying herbicides to marijuana plants, to determine and evaluate the health hazards of the chemicals involved before actually putting them into use.

Psychopathology

It has been known for some time hat marijuana use can produce panic reactions, flashbacks and other emotional disturbances, and that children and adolescents are at high risk psychiatrically when they abuse psychoactive substances.

It is now also clear that persons with a history of schizophrenia or other major mental disorders place themselves in jeopardy by using marijuana, because even acute use has been shown to precipitate psychiatric symptoms in such individuals.

The fact that the marijuana being smoked today is far more potent than that used just a few years ago may bring an increasing number of psychiatric casualties into emergency rooms, crisis centers, and physician's offices. It might also produce confirming evidence of the "cannabis psychosis" reported in other countries where typical dose levels and drug potency have been higher than those heretofore found in the United States.

Research implications

Marijuana is a dangerous drug. A growing body of evidence from both animal and human studies and from clinical observations attests to its deleterious effects on behavior, performance, and functioning of various organ systems. There undoubtedly must be improvement in research design and techniques before definitive incontrovertible data can be secured in certain areas. But that is no reason to hesitate in calling attention to the potentialities for harm as they become clearer and more widespread.

In view of the evidence of possible adverse effects of marijuana use, the sale of, or other trafficking in, marijuana should be subject to stringent penalties and vigorous prosecution.

The AMA has long opposed excessive and unrealistic penalties for possession of small amounts of this drug for personal use. Nevertheless, legislative action that is designed to moderate penalties for possession should be of such as a nature as to discourage use and not to support misconceptions that marijuana is a harmless substance. The fact that marijuana may prove to have therapeutic value in medical practice does not indicate that it is a safe drug for recreational use. Legislators should keep in mind the primary need to give young people a clear message that marijuana use may be hazardous and is not sanctioned or endorsed by society. **Fines, although more appropriate penalties than prison sentences when applied to possession for personal use, should be large enough to constitute a deterrent to use.**

Paraphernalia shops

Retail establishments that specialize in drug-related products have spawned across the country. There are in excess of 15,000 so-called "head-shops" plus an undetermined number of other stores that stock paraphernalia of various kinds. Displayed and sold are machines and paper to roll marijuana cigarettes, pipes and other implements for alternative ways of smoking, and containers for concealing stashes of bulk quantities. Marijuana users are not the only ones catered to. Kits are available for converting cocaine into "free base" which can be smoked, with effects far more devasting than sniffing or inhaling can produce. Measuring devices, scales, instructions, recipes — all pertaining to a variety of psychoactive substances — are there to be examined and purchased.

As much harm as these establishments do in facilitating the abuse of marijuana and other drugs, their chief danger lies in the fact that they often constitute centers for exchange of drug information and for initiating minors into the drug culture.

Pressures brought by parents' organizations and other concerned groups and individuals against such establishments in their communities can be helpful and should be encouraged. Such pressure without legal sanction, however, is not likely to have major impact upon this multimillion dollar industry. Voluntary efforts are probably most successful in limited cases where the supplier or seller unwittingly offers a product that is used adjunctively in drug abuse, and can then be persuaded to withdraw it from the market or curtail its distribution when this fact is called to his attention.

Federal control of this problem would be difficult. The manpower required to enforce national legislation against the marketing of these products would be considerable and might be an undesirable drain on the staffing of other more productive efforts to curb drug abuse.

State and local legislation, on the

other hand, has been effective in some parts of the country. The Drug Enforcement Administration (DEA) has prepared a model act for states that sets forth explicit definitions of paraphernalia, and that makes it a crime to possess such devices with intent to use them for drug abuse purpose, or to make or sell such articles with the knowledge that they are to be so used.

Therapeutic applications

The most promising potential clinical use of marijuana and THC is in the treatment of extreme nausea for patients who undergo cancer chemotherapy.

Well-designed clinical studies have demonstrated the superiority of THC over placebo in this regard. There is conflicting evidence, however, as to the comparative efficacy of THC and prochlorperazine (Compazine), a standard anti-emetic drug. For example, one large study found that THC had "no advantage over prochlorperazine," while another evidenced relatively good response to THC, especially among younger subjects. Both of these studies utilized 10 mg. doses of prochlorperazine, an amount that is at the low end of the recommended therapeutic range of emesis. A majority of 53 patients who were refractory to "aggressive use of standard anti-emetics" and who were later given THC showed improvement, in another study; 10 had no nausea or vomiting, and 28 had partial responses. It may well be that THC's usefulness as an anti-emetic will be greatest among "treatment failures." A large-scale clinical trial of THC with such patients is being conducted under the auspices of the National Cancer Institute.

In this and future studies, it is hoped that differentials in response to THC and in experiencing adverse reactions can be further elucidated. Older patients, for example, seem to respond less well than younger ones, and to complain more about unpleasant drug-induced effects, such as drowsiness, hallucinations, anxiety and tachycardia. More tests also need to be carried out on the relative efficacy of marijuana cigarettes vs. THC capsules as an anti-emetic agent. It may be difficult to standardize the content and potency of marijuana in cigarette form, but some patients find they are unable to swallow THC capsules because of retching and vomiting.

Reduction of intra-ocular pressure in glaucoma is another possible medical use of THC and marijuana that is now being investigated. The comparatively few clinical trials for this indication have yielded encouraging results; additional investigations need to be carried out to uncover any adverse effects and to identify the most active ingredient for this purpose, which may not be delta-9 THC.

The remaining potential therapeutic uses of marijuana are in preliminary stages of research. A few reports of effectiveness of THC in the treatment of muscle spasticity should prompt further investigation and attempts at replication. Much of the clinical applicability of future studies, however, may depend on isolating and determining the action of marijuana's numerous constituents. The cannabis plant contains more than 400 chemicals, including some 60 cannabinoids, and delta-9 THC alone has over 30 metabolites.

Medical use of marijuana and THC, primarily for emesis and glaucoma, is now authorized in more than 20 states (Michigan among them), under statutes providing for varying degrees and kinds of research controls. At least 11 of these states have FDA-approved protocols allowing for physician participation in clinical trials. Other states have submitted protocols for approval. Where such protocols are well designed and followed, there is opportunity for obtaining reliable patient data from numerous sources to augment findings that have been derived from small individual controlled studies.

For those states with enabling legislation that has not as yet been implemented, it is recommended that appropriate regulations and guidelines be established to ensure that bonafide research is carried out, and that medical use beyond the context of clinical investigation is not permitted. For those states that may contemplate legislation in the future, the following features proposed by the FDA should be considered for incorporation in statutes:

1. The law should not be in conflict with rules and regulations imposed by current federal laws, such as the Controlled Substances Act.
2. The law should require coordination with FDA, NIDA, DEA and other relevant federal agencies.
3. It should provide adequate funding for the research.
4. It should recognize abuse potential and provide mechanisms to prevent diversion and misuse during the course of the research.

Conclusion

The perils and promise of marijuana require the continuing attention of the medical profession and the scientific community. The unfolding details of the hazards of abuse and prospects for therapeutic use must be carefully evaluated and interpreted.

As the body of reliable information grows, all segments of society, and young people and their parents in particular, need to be apprised of the facts and their implications. The AMA, state and county medical societies, specialty societies and individual physicians should take a leading role in such educational activities. Physicians themselves should become fully informed, and continuing medical education programs and courses should be developed and made available for this purpose.

As important as prevention of drug abuse is, its victims must not be forgotten. Psychological impairment and physical disorders caused by excessive acute or chronic use of marijuana or other psychoactive drugs, and drug dependence itself, are of major concern to the practicing physician. Working cooperatively with other health professionals and social service personnel, the physician can provide effective comprehensive treatment and, by so doing, reduce the prevalence of drug problems in the future.

References are available.

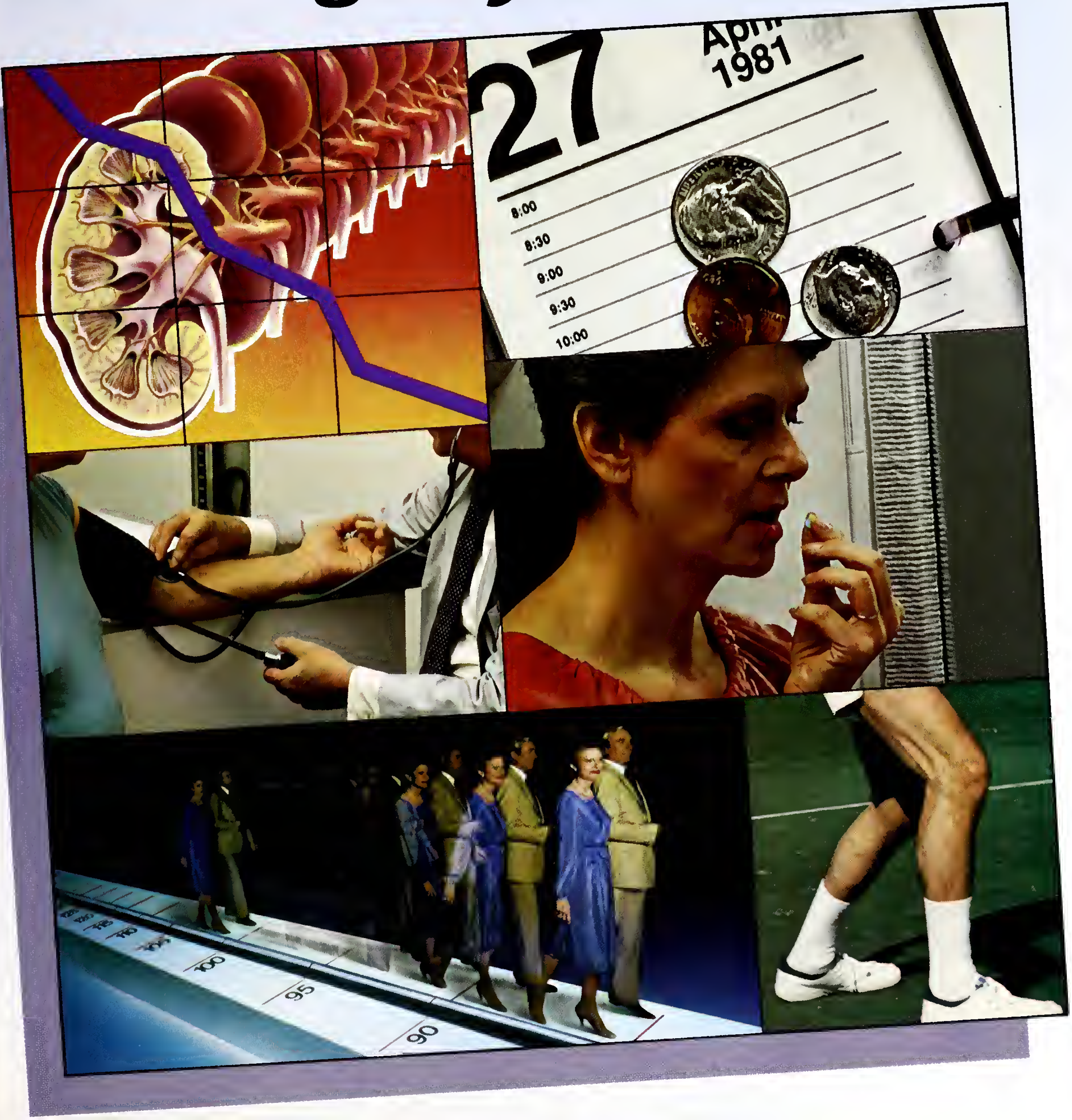
Long-acting

Zaroxolyn®

(metolazone) Pennwalt

2½ mg, 5 mg, 10 mg tablets

The only Step-1 diuretic that can give you all of this...


27
April
1981
8:00
8:30
9:00
9:30
10:00
110
105
100
95
90

Long-acting

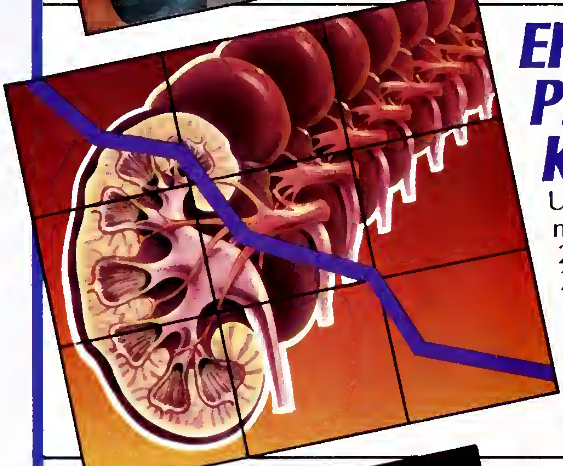
Zaroxolyn® (metolazone

No other diuretic ca

UNSURPASSED EFFECTIVENESS IN STEP-1 THERAPY

No other diuretic has proven superior in antihypertensive efficacy,[1-4] and in well-controlled studies[1,5-9] of patients with mild to moderate hypertension (dBP 90-110 mm Hg):

☐ 74% were normalized by Zaroxolyn *alone* (mean pretherapy dBP=102 mm Hg, mean posttherapy dBP=86 mm Hg)



EFFICACY IN THE PRESENCE OF REDUCED KIDNEY FUNCTION[10-14]

Unlike thiazides and chlorthalidone, Zaroxolyn may be effective in patients with GFR below 20 ml/min. And, unlike chlorthalidone, Zaroxolyn has a secondary effect in the proximal tubule.

Further, since kidney function decreases with age,[15] Zaroxolyn is a rational choice for patients past the age of 40.

LONG-TERM EFFICACY

Zaroxolyn maintains efficacy over long periods without the development of tolerance. In patients with average pretherapy dBP of 115 mm Hg who were followed for 4 years, posttherapy dBP remained at a low 85 mm Hg with Zaroxolyn *alone*.[1,7,8]

rovide all these benefits

SAFETY

linically significant side effects are uncommon ith Zaroxolyn therapy[1,8] —usually no need for $^+$ supplementation.

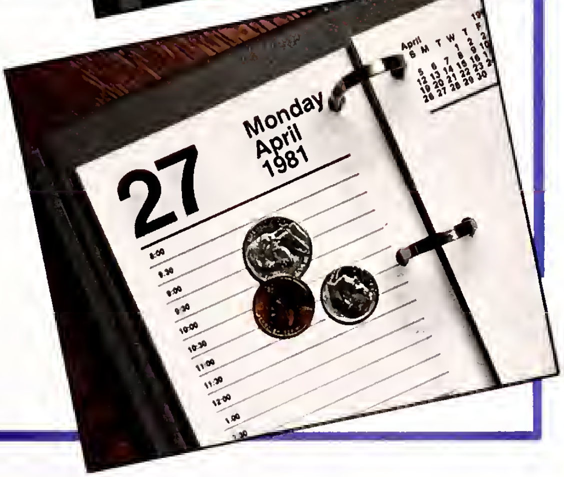
And, because many patients are controlled n Zaroxolyn *alone,* they are spared the possi- ility of Step-2 side effects.

COMPLIANCE

aroxolyn has a 24-hour duration of action, ermitting a single daily dosage.[1,8] Control is nooth and sustained, with little nocturia or ther interference with the patient's lifestyle. hese factors enhance compliance,[14] giving aroxolyn a very low dropout rate (4% due to de effects).[1]

CONOMY

aroxolyn is among the least expensive iuretics available![16] Zaroxolyn is a premium roduct at an affordable price—a product with istinct cost advantages.



ease see following page for prescribing information.

DATE
NAME
ADDRESS
℞
Zaroxolyn
REFILL
TIMES
NON REPETATUR
LABEL

Long-acting

Zaroxolyn®

(metolazone) Pennwalt

Gives you what you want for more of your hypertensive patients

☐ unsurpassed Step-1 effectiveness... maintained over the long run

☐ efficacy in the presence of reduced kidney function

☐ obviates the need for Step-2 drugs for many patients

☐ true once-daily dosage + minimal side effects = outstanding compliance

☐ long-term economy

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma, allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients, dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton, 1976, pp 221-245. 3. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 4. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 5. Van Hoose MC, Cutler RE: Antihypertensive efficacy of metolazone (Zaroxolyn®) alone and combined with reserpine in treatment of essential hypertension. *Current Therapeutic Research* 20:266-276, 1976. 6. Cangiano JL, Campos JA, Trevino A, et al: The effects of metolazone in the long-term treatment of essential hypertension. *Current Therapeutic Research* 16:778-785, 1974. 7. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 8. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 9. Materson BJ, Oster JR, Perez-Stable EC: Antihypertensive effects of metolazone (Zaroxolyn). *Current Therapeutic Research* 16:890-896, 1974. 10. Puschett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 11. Craswell PW, Ezzat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 12. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 13. Dargie HJ, Allison MEM, Kennedy AC, et al: Efficacy of metolazone in patients with renal edema. *Clin Nephrol* 2:157-160, 1974. 14. Anderson RJ, Hart GR, Lee OK: Pitfalls in management of essential hypertension. Diuretic therapy. Second in a series on antihypertensive drugs. *Primary Cardiology* 5:63-75, 1979. 15. Papper S: *Clinical Nephrology*. Boston, Little Brown & Co, 1971, p 17. 16. *Drug Topics Red Book 1981*.

℞ DIVISION
PENNWALT
ROCHESTER, NEW YORK 14623

A-287

The Pap Smear: Guidelines for performance

A statement prepared for the Michigan State Medical Society by the Professional Education Committee, Michigan Division, American Cancer Society, in cooperation with the MSMS Committee on Maternal and Perinatal Health, Lee B. Stevenson, MD, chairman.

Please remove this page for filing.

Recently in the popular press, the "Pap Smear" has been reported as being unnecessary on an annual basis. Strong, conflicting, and at times emotional, views have been expressed on this point by many. But the consensus is that the issue is best addressed by the patient and her private physician.

The record of the "Pap smear" has been clearly established in reducing deaths from carcinoma of the cervix. A properly performed smear can identify pre-malignant changes and frank carcinoma of the uterine cervix and it can occasionally detect cervical abnormalities due to Herpes Type II, Chlamydia and Actinomyces cervicitis.

Since an improperly performed and/or interpreted smear can give a false sense of security to the patient and her physician, we offer the following guidelines for an acceptable smear.

Indications for a Pap Smear:

1. All sexually active women.
2. All women through the age of 60.
3. Women who are post-hysterectomy for malignant disease of the female reproductive organs.
4. Pap smears can be taken during any stage of pregnancy. However, caution is advised in the bleeding patient.

Acceptable Pap Smear sampling techniques:

1. Examine the patient during the non-bleeding part of her cycle (ideally mid to late cycle) with a dry or slightly water moistened speculum to give adequate exposure of the entire cervix and upper vagina.
2. Obtain good sampling of the exocervix including the "transformation zone," and the endocervix. Patients with a DES history and/or clinical findings need an upper vaginal sampling on an additional slide.
3. Apply cell samples *promptly* onto thin glass slides. Smear sample moderately thin so as to avoid excess cellular overlapping.
4. *Immediately* "fix" the slides with an alcoholic fixative. This spray fixative should be held 8-12 inches from the slide so the cellular sample is not disturbed.
5. Print the patient's name on the frosted corner of the slide plus the site the smear was taken from.
6. Complete the accompanying lab requisition giving pertinent clinical information, including risk status, the appearance of the cervix, past history of abnormal findings, medications (see below), contraceptives, the date of the first day of the last menstrual period.
7. Send specimens to an accredited laboratory with well-trained pathologists and cytotechnologists. Visit your lab and become acquainted with their cytologic terminology. Communication between the clinician and the laboratory personnel is extremely important.

Additional diagnostic recommendations

1. Biopsy any visible suspicious lesions at the time of the Pap examination; perform the smear prior to the biopsy in order to avoid excess blood on the smear.
2. Prompt followup of any "atypical" report is recommended (i.e. colposcopy and colposcopic-directed biopsies).
3. If the cytology report is "unsatisfactory," notify the patient and repeat the smear. "Unsatisfactory" refers to one of the following:
   a. Insufficient cells and/or scanty material.
   b. Excess talc or speculum jelly on the smear.
   c. Obscuring (heavy) inflammation, infection or blood.
   d. Air-dried ("washed-out") smears.
   e. No endocervical cells on the slide indicates probable lack of sampling of the transformation zone. Metaplastic cells are used synonymously with endocervical cells in this context. Cervical stenosis, pregnancy, or internalization of the transformation zone may prevent sampling of the transformation zone.

Contraindications to performing a Pap Smear

1. Menstruation.
2. If a douche or vaginal medication has been used in preceding 48 hours.
3. Cryosurgery or cautery within the previous three months.

Some causes of false positive Pap Smears

1. Recent cryocautery (under three months).
2. Recent Podophyllin topical therapy (Podophyllin should not be used on the cervix).
3. Folic acid deficiency.
4. Corticosteroid medication.
5. Digitalis.
6. Recent (three-six months) pelvic irradiation.
7. Inflammation or repair related to infection or recent therapy.

High risk factors related to cervical neoplasia

1. Early age at first coitus.
2. Multiple partners, especially in the teens.
3. First pregnancy under age 20.
4. Multiple early pregnancies.
5. History of sexually transmitted diseases, e.g., gonorrhea, syphilis, Herpes Type II, trichomonas, Chlamydia, condylomata and hemophilus.
6. High risk: male exposure.
    - a. Occupational group of husband is important; Manual laborers have three times greater risk as compared with professionals.
    - b. Genital cancers found in other sites, i.e. penile or prostatic malignancies.
    - c. Sexual promiscuity with or without history of venereal disease.

Factors unrelated to cervical neoplasia

1. Family history.
2. Menstrual history.
3. Parity per se.
4. Diet.
5. Chronic non-specific cervicitis per se.
6. Mechanical irritation.
7. Exposure to external carcinogens, e.g., coal tar products, such as douches or vaginal applications.

How often should the Pap Smear be done?

1. After two negative Pap smears, rescreening should be on a regular basis at the physician's discretion (probably one to three years), depending on risk factors.
2. High risk patients, with dysplastic and CIN findings, should be followed more closely, at least semi-annually.

Conclusion

The optimal yield of cervical carcinoma utilizing the Pap Smear is the combined responsibility of the patient, clinician, cytotechnologist and pathologist. Cytologic examination of Pap Smears according to the guidelines outlined above will not detect every case of cervical carcinoma, but will detect most. The Pap Smear is the most practical technique for the initial discovery of abnormalities of the uterine cervix. Its regular performance according to the above guidelines is recommended.

Manuscript prepared by S. Leonard Cohn, MD, and Barbara E. Mahoney, MScMT, CT (ASCP).

New, competitive reimbursement systems put health care cost, use decisions at local level

By David Raymond and Fred Patterson, MD, Ann Arbor

Recent years have witnessed a constant argument regarding the effects of cost containment activities on the quality of care. Can it be a constructive relationship? Is it always a destructive relationship?

Medical staffs across the state now have the opportunity to influence this relationship in their hospitals, as the prospective rate reimbursement system in Michigan and any future competitive health care systems will probably place decisions regarding the use of health services at the local level. While this reduces regulatory intrusions, it increases the financial risk and the need for professional involvement within each hospital.

Prospective reimbursement schemes will affect medical practice in the hospital setting. Cost containment activities such as energy savings, changes in (nonmedical) support services, mergers and accounting practices are only relatively minor "one shot" measures.

The real challenge will be altering the way physicians practice, especially the services they order. In the same way that "cost-plus" reimbursement fostered an explosion in the use of ancillary services, the prospective rate reimbursement systems recently implemented by Blue Cross Blue Shield of Michigan and by Medicaid are the beginning of new reimbursement systems which will encourage the selective use of diagnostic and therapeutic services.

While many of us may welcome a return to a greater emphasis on the physicians' clinical and diagnostic skills, the new reimbursement systems will challenge the medical profession to reconcile the continuing expansion of medical technology with the lessening ability to pay for such services.

David Raymond is Ancillary Services Project Director for Area VII PSRO. Doctor Patterson is chairman of the Ancillary Services Committee.

The Prospective Rate Reimbursement Systems of Blue Cross Blue Shield of Michigan and of Medicaid are designed as cost containment strategies. In them, hospitals are guaranteed a more stable source of revenue plus increased freedom in allocating revenues in exchange for keeping projected budgets under a statewide budget screen. While hospitals may elect to undergo budget review for projected budgets over this screen, the entire Blue Cross Blue Shield of Michigan prospective rate reimbursement system must contain health care costs in Michigan or face the probable institution of a rate review program. Consequently, budget review is a carefully managed and limited alternative to remaining under the statewide budget screen.

The statewide budget screens are related to inflation, but they also are designed to become stricter over time — allowing hospitals time to adjust to a new system. Consequently, hospitals will face an increasing need for cost containment and resource allocation decisions.

While there is an adjustment factor for significant increases (greater than 1½%) in hospital day use, there is no adjustment factor for an increasing intensity of services. Thus, if a hospital experiences a continuing increase in the intensity of services resulting in increased departmental costs, a hospital may find itself in financial jeopardy under the prospective rate reimbursement system. Some hospitals already are experiencing this.

Unacceptable solution

Failure to address the issue of the appropriate use of diagnostic and therapeutic services frequently results in a decreasing ability to fund the operational expenses of new programs and services. Under this solution, as the budget screens are reduced in Michigan, we should expect fewer new programs to be initiated. Another result would be increasing workloads for hospital personnel, which in turn leads to lower morale and poorer quality of the individual services rendered. This phenomenon was addressed in greater detail by the May 26, 1980 issue of *Medical Economics*.

Acceptable solution

Common sense suggests two more reasonable approaches: (1) increasing the efficiency of the hospital departments and; (2) reducing the avoidable use of services. Ancillary service departments have flourished under cost-plus reimbursement systems. They have been the profit centers of the hospitals and rapid expansion was desirable. There has been little need or desire to focus energies on efficiency or assuring only appropriate use. To the contrary, administrative energies have had to focus on the management of frequent change and growth.

Improving the efficiency of ancillary departments entails more than increasing productivity. Productivity can be improved by increasing the output while holding resources constant. This action is a limited solution. Improving the efficiency of ancillary departments requires identifying and resolving departmental and interdepartmental problems that cause inefficiency (i.e., abuse of STAT orders, delayed reports). It may also include changes in purchasing and in operational procedures (i.e., group purchasing, scheduling). Physician involvement in improving departmental efficiency ensures protection against changes which might negatively affect quality.

Reducing the inappropriate use of services frees present operational resources, especially personnel, to be available for new programs and services.

This is an important goal since the implementation of many new projects is held back, not by capital limitations, but by operational funding limitations. There are many approaches to identifying and reducing

REIMBURSEMENT/*continued*

inappropriate uses of ancillary services. These include:

- Reducing obvious inappropriate use.
- Reducing unproductive routine testing.
- Challenging wide variations in physician practice patterns for similar patients.
- Training residents in efficient ordering practices.
- Establishing concurrent review mechanisms of repetitive orders.
- Auditing selected tests or services to identify variations in practice and/or significance to potential outcome.
- Cost review during grand rounds and morbidity and mortality conferences.

Physician involvement

Physicians cannot and should not expect administrative solutions to be completely to their liking. Whether through regulation or through competition, the need for cost containment will remain strong. Both of the proposed acceptable solutions of improved efficiency and reduced use of avoidable services will have an impact on physician practice habits as department procedures are altered and avoidable use patterns are questioned.

Consequently, there not only is a need but also it is in the best interest of physicians to become intimately involved in the strategies and decisions needed to meet this challenge. As indicated earlier, this involvement will be largely at the individual hospital level. To encourage the involvement of physicians, the specific methods selected must (1) be convenient, (2) be seen as the least interfering alternatives, and (3) acknowledge the authority and responsibility of the individual and corporate medical staff in the appropriate use of services.

PSRO role

Professional Standards Review Organizations could become very useful in protecting the future quality of care while new reimbursement mechanisms emphasize cost containment. Putting aside the governmental regulatory side of PSROs, they have a number of good points which may make them uniquely valuable to physicians in the future, including:

- Physician control
- Review expertise
- Interhospital data capabilities
- An external perspective
- Confidentiality protection
- Legal authority and protection

The above attributes provide physicians with an established, external organization under local physician control to develop and implement professionally-developed solutions to the challenge of the new reimbursement mechanisms.

As the federal government works to restructure the present health care system, physician groups may choose to develop new forms of professionally based review organizations to provide private services on a contractual basis. A possible role of such physician review organizations may be that of a consultant to provide information and technical assistance regarding available strategies, criteria and standards, profiling and comparative data. The medical staff at each hospital would determine its desire or need for such consultative services and would remain in control of the selection and use of strategies.

Here's help with arbitration questions

By Randy A. Watkins, Lansing

The Michigan Insurance Bureau receives many complaints pertaining to the offer of arbitration by health care providers. These complaints show that some health care providers may not be properly informed about the basic requirements of the arbitration laws.

The law requires that the patient be given a Patient Information Booklet and arbitration agreement form at the time the offer is made and that signing an arbitration agreement not be a prerequisite to health care.

Two complaints recently received by my office illustrate common misunderstandings of the arbitration law.

In one complaint, a physician required patients coming to his office to sign the arbitration agreement before he would accept them as patients.

While the law does not require physicians to offer the arbitration agreement to patients making office visits, it is quite clear that when physicians do offer arbitration, they must not require their patients to sign the agreement. The Michigan Court of Appeals has ruled: "Where health care is preconditioned upon the signing of an arbitration agreement, a coercive atmosphere is created undermining the free will of the party seeking health care and thereby vitiating the arbitration agreement.

In the second complaint, a physician left the operating room after a child had been anesthetized for a tonsillectomy to obtain the parents' signature on the arbitration agreement. The parents refused to sign the agreement and removed their child from the hospital without the surgery being performed.

By leaving the operating room and asking for the parents' signature, the physician established a "coercive atmosphere." This could be cited as a violation of the law and the court could find that the arbitration agreement is invalid in the event of a malpractice claim. The physician's action might also leave him vulnerable to other types of litigation such as breach of contract and action to obtain a refund of any fees that may have been charged. A physician might leave the hospital vulnerable to these types of litigation.

I would be happy to answer any questions about offering arbitration either in a physician's office or in a hospital. Please feel free to contact me at:

Medical Arbitration Program
Michigan Insurance Bureau
Department of Licensing and
Regulation
Box 30220
Lansing, MI 48909
or phone (517) 373-0435

Mr. Watkins is coordinator, Medical Arbitration Program, Michigan Insurance Bureau.

An added complication... in the treatment of bacterial bronchitis*

Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin-Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [103080R]

---

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* [8]

Note Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

1 Antimicrob Agents Chemother , *8* 91, 1975
2 Antimicrob Agents Chemother , *11* 470, 1977
3 Antimicrob Agents Chemother , *13* 584, 1978
4 Antimicrob Agents Chemother , *12* 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880 Washington, D C American Society for Microbiology, 1978
6 Antimicrob Agents Chemother , *13* 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr , and J E Bennett), p 487 New York John Wiley & Sons, 1979

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

100061

MDs should continue to support PSROs

By Robert E. Medlar, MD, Jackson

I believe the AMA made a serious mistake in calling recently for the end of PSROs.

It is illogical to think that in the present political climate of cost containment, crusades against fraud and abuse, fair treatment of the truly poor and wise spending of the taxpayers' billions of health dollars, that a system which already addresses these problems should be dumped.

Requirement for peer review of federally-subsidized hospitalized patients already is built into the law, as it was for Medicare Part A and B and subsequently Medicaid.

Discontinuing PSRO will shift review to some other agency. *No review* is not an option. Other agencies could be other third-party payers, such as the Blues or the Michigan Department of Social Services.

But with review in their hands, any vestige of control by local physicians of quality of care would be lost. How patients are treated in our hospitals should be reviewed by physicians who understand that care, not by a bureaucracy which not only lacks expertise, but would be more likely to be concerned with the dollar sign than with quality.

In carrying out the job of review, PSROs throughout the country have necessarily gathered data — enormous amounts of data on patients, hospitals, patient profiles, illness incidence, death rates, operation frequency, length of stay, and on and on. In the present system, physicians are carefully screening this data under strict confidentiality and with the knowledge of the complexity of the practice of medicine. Should PSROs be discontinued all of this information stored in data banks becomes available to the next functioning agency. How this information might be used is unknown. But the potential for harm is there. Conclusions might be hastily reached and broadcast without careful research by knowledgeable professionals necessary to reach valid conclusions.

Doctor Medlar is a member of the MSMS PSRO Liaison Committee.

The MSMS Medicaid Liaison Committee has had its first meeting with its new chairman, Allen F. Turcke, MD, left, Flint. With Doctor Turcke, above, is Thomas M. Flake, MD, committee member.

PSRO s work

PSROs have been effective in reducing the total cost of hospitalization. They persuaded the Michigan Department of Social Services to drop pre-admission certification of elective Medicaid cases and mandatory, across-the-board, one-day preoperative stays for elective Medicaid surgery. PSROs now determine which cases are medically necessary — not Medicaid or Medicare. They have identified and corrected instances of faulty practice. They have, with a modicum of irritation, kept all of us on our toes.

It seems stupid to substitute an unknown future system for one which already is in place, cost-effective, run by the right people — in short, doing the job for which it was intended.

Peer review always has been a part of our professional practices. It is this self-discipline which is central to the concept of professionalism. Our hospital staffs are structured to oversee the care provided to patients in our hospitals. How well this functions is dependent on the will and dedication of leaders.

Few of us accepts criticism gracefully. All of us could do better. Doesn't it make sense that federally-mandated peer review should remain in the hands of professionals? I urge you to give your continued support to PSROs.

IF THEY CAN'T PAY YOU NOW,

IT WILL HURT YOUR PRACTICE LATER.

If he owes you money, you may have lost him as a patient. But you've also lost his family and potential referrals. You can't afford that. Let I.C. System help. Approved by your professional association, this collection service clears up bad debts in an ethical and courteous way, leaving the door open for your patient to return. Mail this coupon today to learn how...

The System Works

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ____________________
Address ____________________
City ____________________
State ____________________ Zip ____________
Signature ____________________

In January
4,631
Michigan
physicians
were very happy
because of us.

Here's why:

Rates

Effective January 1, 1981, the Michigan Physicians Mutual Liability Company (MPMLC) reduced its rates for the **third** time in **three** years. Sixteen of the eighteen basic class and territory rates were reduced. The overall reduction averaged **9.7%** for MPMLC's 3500 insured physicians.

For example, a Territory 1 anesthesiologist **saved $925** for $200/600 coverage. In Territory 2, an ob/gyn surgeon **saved $1888** for $200/600 coverage.

1980 Dividend

The Board of Directors of MPMLC, all fellow Michigan physicians, declared a 5% dividend to 1980 policyholders. As a mutual company, MPMLC is able to pay a dividend to its policyholders who own the company. The dividend is **in addition to** the above rate decrease.

Interest Payment

MPMLC paid interest of 7% per annum to 4,631 physicians and physician groups who purchased Surplus Certificates in past years. The purchase of a Surplus Certificate is **no longer required** for insurance.

If you weren't one of the physicians who saved money or received a dividend from MPMLC, maybe it's time you looked into the exceptional insurance coverages we provide.

MPMLC is Michigan's 2nd largest provider of professional liability insurance for physicians and 25th largest in the United States. It is run by physicians. . .for physicians. MPMLC is your company.

Michigan Physicians
Mutual Liability Company

P.O. Box 1471
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926 toll free

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Rep. Ballentine: ‘Government failed by giving everybody everything’

By Willah Weddon, special to Michigan Medicine

Rep. Ballentine

This article is part of a continuing *Michigan Medicine* series on state legislators of key interest to medical interests in Michigan.

Michigan's financial woes will affect the medical profession in several ways during 1981, predicts State Representative Mary Keith Ballentine, Jackson Republican. A member of the House Public Health committee, Rep. Ballentine was reelected last November to her second two-year term in the House, and she is concerned with economic prospects.

There is going to be a slow-down in implementation of the Public Health Code, she says, adding that much of it was to have been implemented in 1980 but was held back by lack of state funds.

State budget

“Another issue will be Medicaid payments. How we are going to get funds for physicians so they'll be willing to provide service for Medicaid patients, is important,” she points out. “Sometimes I get information there is concern about the eligibility of some recipients . . . it's a very difficult thing to control.”

“It's imperative we continue to give poor people good medical service. But I believe the very best way to work this out is to have Medicaid patients pay a small amount for prescriptions and physician's services so they will think before seeking medical attention.

Placing a small charge on some services was considered but was not included in the final Department of Social Services appropriations bill as it passed the legislature in late November, she notes.

Rep. Ballentine also favors preventive medicine as a means of reducing Medicaid costs. For instance, she believes providing health education about nutrition could play an important role in motivating people to recognize their own self-interests and give them the incentive to take good care of themselves.

Unlike some Republicans, Rep. Ballentine is not discouraged by being a member of the minority party. She feels much can be accomplished in committee work (committees are chaired by the majority party members) and by amending proposed legislation.

The first woman elected from the 23rd District, she represents eight townships, plus a fragment of another, in Jackson County; 13 in Washtenaw County and one in Ingham County. She has established a reputation for “doing her homework” and, although she prefers to be “low-key,” states her convictions clearly after reaching a decision.

Excessive paperwork and duplication in governmental activities have long been anathema to the former Jackson County Commissioner, University of Kentucky and Indiana University (MA) graduate.

“We're getting so caught up with paperwork it seems as if people spend more time filling out forms than giving service,” she contends. “I'm not sure the taxpayer's dollar is well spent on regulations.”

Ballentine plans to re-introduce a bill in the new session which would require an annual paperwork report to the legislature. It would require an inventory of all reports and would try to coordinate them. Information could be available, she believes, in a central location so entire new forms needn't be created for several agencies.

“Another thing is the matter of duplicate inspections conducted by various departments,” she continues emphatically. “We need to find some mechanism for a team approach so every department doesn't have to drive up to the Upper Peninsula, as an example, to do their own inspection.”

Medicaid abortions

Mother of two grown children and wife of a banker, Mrs. Ballentine is also deeply concerned about Medicaid paying for abortion-on-demand. “We wouldn't tell our children at 16, ‘We don't want you to have intimate relations, but if you do, we'll furnish an abortion for you’ . . . and that's what the state is doing to these families.”

“I have yet to find some method through education and motivation to help women understand it isn't in their own best interest to have abortions,” she says.

“I think government has failed by giving everybody, everything,” Rep. Ballentine insists. “I see the role of government as helping people to help themselves . . . and we haven't been doing this.”

She'd like to see counseling required by referral to the family planning clinic in local public health departments, after a woman has an abortion. “This would provide a woman with an education to help herself.”

This issue is typical of many Rep. Ballentine believes should be studied thoroughly by many people before legislative action takes place.

“Good politicians have a skill, I think, of pulling together information from various sources and coming up with something that will work,” she says. “But we don't have time to do this.”

Convinced that better legislation would result from longer preparation and passage of fewer bills, she refers to Wisconsin's legislature as an example. “They meet as often as we do, but spend two months studying topics before having a voting session,” she points out. “This enables them to call in experts, hear testimony and ask questions of many sources.”

In G.I. therapy

Adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer*
and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

> **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
>
> "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
>
> Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

Roche Products, Inc.
Manati, Puerto Rico 00701

"We're together because Dr. Benson recommended home health care."

Home health care is an excellent alternative when your patients cannot fully care for themselves, yet do not need to be in a hospital or nursing home. They can enjoy the comforts of home and family while receiving the care they need, often at a cost far below that of institutional care. And you are always in full control of the plan of care.

Each year, thousands of people receive care at home from Upjohn HealthCare Services.SM We employ nurses, nurse assistants, home health aides, homemakers and companions.

We're the nation's leading private provider of home health care, with hundreds of offices throughout the United States and Canada. Many of our offices are licensed to provide services covered by Medicare.

Upjohn HealthCare Services is a service program of The Upjohn Company, a name you and your patients can trust. For free home health care information packets you can give to your patients, please send us the coupon below. Or call our office nearest you, listed in the white pages of your telephone directory.

Upjohn
UPJOHN
HEALTHCARE
SERVICES SM

Let us help you tell your patients about home health care.

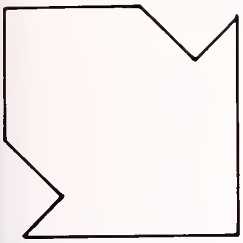
Please ☐ send me 10 free home health care information packets
☐ have your service director call me

Name ____________________
Address ____________________
City __________ State ______ Zip ______

Mail to: Upjohn HealthCare Services
Dept. SJG
3651 Van Rick Drive
Kalamazoo, Michigan 49002

HM-6743 c 1981 Upjohn HealthCare Services, Inc.

NEW MEMBERS



Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Marvin D. Anderson, MD IM
Henry Ford Hosp.
Detroit, 48202

Louis C. Argenta, MD PS
U of M Outpt. Bldg. C-7040
Ann Arbor, 48109

Suresh G. Bilolikar, MD P
6090 Athens
Troy, 48098

Bruce J. Bobofchak, DDS
1675 Leahy St.
Muskegon, 49442

Timothy J. Bodnar, MD EM
Henry Ford Hosp.
Detroit, 48202

Delbert L. Brown P
165 N. Washington
Battle Creek, 49916

Harold Copans, MD IM/CD
2799 W. Grand Blvd.
Detroit, 48202

Jose Q. DeGuzman, MD U
821 Water St.
Hancock, 49930

Douglas A. Edema, MD FP
260 Jefferson Ave., S.E.
Grand Rapids, 49503

Errol E. Erlandson, MD GS
U of M Medical Ctr. B3900 CFOB
Ann Arbor, 48109

Barry J. Evans, MD PD/IM
36256 Fredricksburg
Farmington Hills, 48018

Sham S. Gandhi, MD OPH
114 W. North St.
Owosso, 48867

T. S. Ganesh, MD P
1035 S. 24th St.
Battle Creek, 49015

James M. Grubka, DDS
299 E. Columbia Ave.
Battle Creek, 49015

Madam Lal Gupta, MD PD/NPM
2741 Aldgate
Bloomfield Hills, 48013

Donald M. Heggen, MD OBG
1900 Wealthy St., S.E. #300
Grand Rapids, 48506

Miguel A. Hernandez, MD ORS
4520 Firestone
Dearborn, 48126

Archie B. Hooton, MD P
20755 Greenfield Rd.
Southfield, 48075

Donald C. Jackson, MD GS
1054 Fisher Bldg.
Detroit, 48202

Jae Chul Kim, MD P
2110 W. Hill Rd.
Flint, 48507

Jin Guk Kim, MD AN
Henry Ford Hosp.
Detroit, 48202

John W. Konnak, MD U
U of M Ctr. C-5112
Outpatient Bldg.
Ann Arbor, 48109

Jai Duck Liem, MD PM
33155 Annapolis
Wayne, 48184

John L. Mixer, DDS
3735 Farmwood
Muskegon, 49441

Felcar L. Morada, MD FP
1420 Leafgreen
Troy, 48084

Pain Management for the Practicing Physician
A Conference on Diagnosis and Therapy

Thursday, May 21, 1981
8:30 a.m. to 5 p.m.

At the Detroit Engineering Society
110 Farnsworth, Detroit, Michigan

Sponsored by the Gertrude Levin Pain Clinic and
the Comprehensive Cancer Center of Metropolitan Detroit

Register early. Approved for 8 CME credit hours.

For more information, call (313) 577-1848

family practitioners

Seeking a board certified/eligible family practitioner to join family practitioner and general internist in a high quality growing practice in northcentral rural Wisconsin. Modern clinic building adjoined to community hospital. Call shared with two other physicians in a nearby community. Associate membership, then membership affiliation with a large multispecialty medical group 60 miles distant offering the full spectrum of consulting services and providing laboratory and administrative support and continuing medical education opportunities. Salary and fringe benefits excellent. Practice experience desirable but not mandatory. This is an excellent opportunity to exercise your talents in adult medicine, pediatrics, and OB-GYN in a small community environment practicing with skilled colleagues while enjoying a reasonable call schedule, freedom from business administration, and the security of ready access to consulting specialists in all fields. Send curriculum vitae and the names of persons who can be contacted for reference to:

FREDERIC WESBROOK, M.D.
Marshfield Clinic
1000 North Oak
Marshfield, WI 54449

WELCOME/*continued*

K. V. Mune-Gowda, MD HS/GS
76 W. Adams #1408
Detroit, 48226

Michael L. Nahrwold, MD AN
Univ. Hosp. Dept./Anes.
Ann Arbor, 48109

Christopher J. Pabian, MD FP
19130 Sumpter Rd.
Belleville, 48111

William H. Pfeffer, MD OBG
Henry Ford Hosp.
Detroit, 48202

John L. Proctor, MD IM
1301 Main St.
Buchanan, 49107

Lena H. Saadi, MD OTO
3901 Beaubien Blvd.
Detroit, 48201

Karen L. Seaver, MD IM
1675 Leahy St. #420
Muskegon, 49442

Enrico C. Sobong, MD IM/ON
515 Lakeside Dr., S.E.
Grand Rapids, 48506

Richard M. Stiphout, MD IM
1863 Norfolk
Birmingham, 48009

Sarada Subramanian, MD DR
U of M Medical Ctr.
Ann Arbor, 48109

Raul Cesar Tamayo, MD IM/END
2845 Woodcreek Way
Bloomfield Hills, 48013

Camille E. Brown, MD EM
2742 Granada Dr., 3-D
Jackson, 49202

Mark G. Campbell, MD ON/IM
21 Michigan St., NW
Grand Rapids, 49503

John W. Foderick, MD GS/CRS
770 N. Main St.
L'Anse, 49946

Jennifer E. Frank, MD FP
775 S. Main St.
Chelsea, 48118

Maria A. Gutierrez, MD AN
P.O. Box 188
Adrian, 49221

Richard S. Hansell, MD OBG
820 Lester Ave.
St. Joseph, 49085

Thomas W. Henderson, MD IM
820 Lester Ave.
St. Joseph, 49085

Carolyn D. Hoekstra, MD OBG
608 Irwin
Albion, 49224

Tehmina Husain, MD OBG
228 S. First St.
Harbor Beach, 48441

Jeffrey M. Jones, MD N
876 Sylvan Dr.
Battle Creek, 49017

Melinda E. Karam, MD PD
28421 Eldorado Place
Lathrup Village, 48076

Sita Ram Kaura, MD EM/GP
1640 Fort St., E.
Trenton, 48183

Robert C. Lesher, MD ORS
1018 S. 13th St.
Escanaba, 49829

Michael D. Levine, MD EM
27027 W. 13 Mile Rd.
Franklin, 48025

Frank R. Neher, MD IM
3328 Alpine Dr.
Ann Arbor, 48104

Douglas G. Pankratz, MD ORS
1060 S. Van Dyke #4
Bad Axe, 48414

Chan Kee Park, MD OBG
46102 Donahue Dr.
Mt. Clemens, 48044

Vladimir Schwartsman, MD ORS
1007 E. Fork Dr.
Flint, 48503

Jae Yong Shim, MD N/P
235 North Ave. #3
Battle Creek, 49017

M. Ishwara Bhat, MD IM/CD
1 So. Fifth St.
Niles, 49120

J. R. Bhavnagri, MD OBG
45420 Van Dyke
Utica, 48087

Daniel H. Bock, DO DR
1700 Oak Ave.
Muskegon, 49442

Richard S. Boss, MD FP
230 W. Oak St.
Fremont, 49412

Theodore Cooper, MD GS
The Upjohn Co.
Kalamazoo, 49001

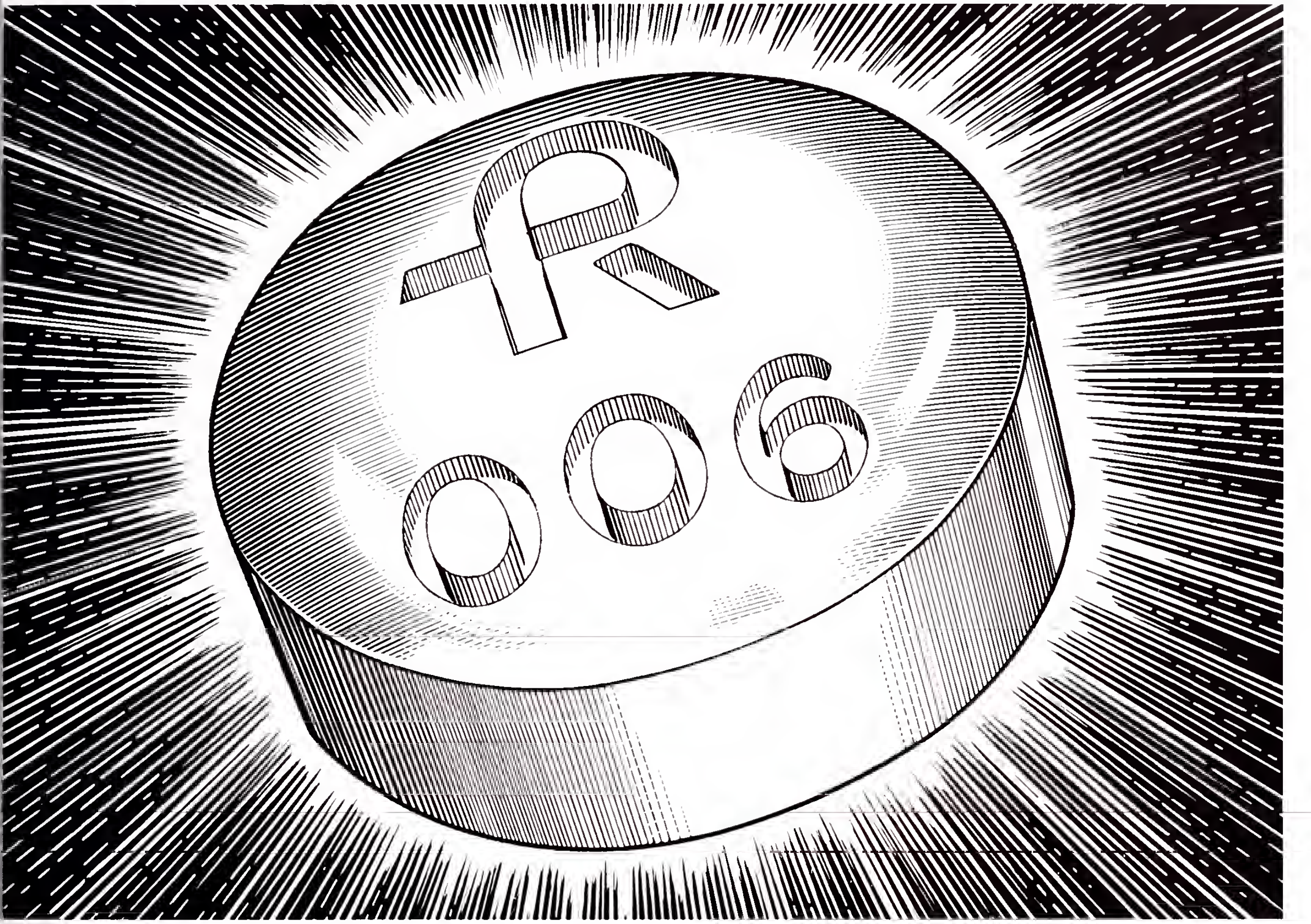
Mark F. Deatherage, MD GS
550 Osborn Blvd. #1004
Sault Ste. Marie, 49783

Noemi M. Faustino-Inocencio, MD IM/FP

continued on page 178

Will your generics need a lawyer?

Beware! Many state laws, now in effect or proposed, require the identification of product, strength and manufacturer on each solid doseform to be legal for generic substitution. If you dispense unidentified drugs, after effective date of legislation, you're dispensing in violation of such laws.



Purepac generics coded for legal substitution.

Purepac's coding system, to be phased in during 1981, will meet every state's legal requirements. Tablets and capsules will be imprinted with a code number and Purepac's symbol. This symbol ℞ identifies a Purepac product. The code number designates the name of the product and its strength. For rapid identification, these code numbers will be listed in Purepac's catalog and the *Physician's Desk Reference*. This system provides instant identification which can prove useful in saving lives from accidental overdose.

Watch out for serious offenders.

Will your generic pharmaceutical supplier be able to meet all identification requirements—especially if that supplier is not a manufacturer? Products not properly coded then violate the law! And by dispensing them, you're substituting illegally. And taking big risks.

Don't take chances. Be sure you're dispensing a legal generic. Be sure it's Purepac!

PUREPAC

PHARMACEUTICAL CO.
Division of Kalipharma, Inc.
Elizabeth, New Jersey 07207

Over 50 years of service to pharmacy.

GN-0381

WELCOME/*continued*

421 Pioneer Rd.
Berrien Springs, 49103

William P. Gifford, MD FP
632 E. Roosevelt
Battle Creek, 49017

Raymond L. Gonzalez, MD AI/IM
1001 Medical Park Dr., S.E.
Grand Rapids, 49505

Antonio J. Grillo-Lopez, MD HEM/ON
2800 Plymouth Rd.
Ann Arbor, 48105

Merle A. Haanes, MD D
909 Woodward Ave. #110
Pontiac, 48053

Syed M. Hasan, MD U
294 N. Maple St. B
Tawas City, 48763

Jeremy J. Hollerman, MD EM
830 S. Jefferson
Saginaw, 48601

Thomas A. Hoyt, MD AN/IM
333 Greentree Ln.
Ada, 49301

Fouad W. Kai, MD GS
117 S. Burgess St.
West Branch, 48661

Howard M. Kaplan, MD IM/PUD
241 Hillcrest
Grosse Pte. Farms, 48236

Robin D. Kelmenson, MD IM
15901 W. 11 Mile Rd. #205
Southfield, 48076

Frederick L. Lawrence, MD FP
2625 Townline Rd. Box 785
Houghton Lake, 48629

Bradford Y. Lee, MD TS/CDS
1717 Shaffer
Kalamazoo, 49001

Barry A. Lerman, MD PD
2901 S. Westnedge Ave.
Kalamazoo, 49008

Chin-Ti Lin, MD U
770 Riverside Ave. #205
Adrian, 49221

Charles R. Luttenton, MD DR
21 Michigan Ave., N.E.
Grand Rapids, 49503

Lee Marmion, MD N/IM
21 Michigan St., N.E.
Grand Rapids, 49503

Timothy C. Mead, MD ORS
210 Lafayette, S.E. #304
Grand Rapids, 49503

K. Mohanachandran, MD IM/CD
3521 State St.
Saginaw, 48602

Jeanne Mohler, MD FP
632 North Ave.
Battle Creek, 49017

Frank W. Moler, MD PD
292 E. Chicago
Coldwater, 49036

Jeffery C. Morgan, MD FP
632 North Ave.
Battle Creek, 49017

John R. Musich, MD OBG
1357 Wrenwood
Troy, 48084

Reddivalem V. Nagesh, MD IM/NEP
1023 E. Ganson
Jackson, 49201

Alan A. Palmer, MD GS
Mill Road Prof. Bldg.
Adrian, 49221

Philip C. Ptacin, MD FP
154 West St.
Battle Creek, 49017

David N. Pugh, MD EM
830 S. Jefferson
Saginaw, 48601

William K. Purdy, MD PD
64 Bronson Medical Center
Kalamazoo, 49006

Mohammad A. Rahman, MD GS
9880 E. Michigan Ave.
Salesburg, 49053

Harish Rawal, MD NS
761 W. Michigan Ave.
Jackson, 49201

Kurt Richardson, MD OTO
MSU Clinical Ctr. B435
East Lansing, 48824

James D. Taborn, MD IM/RHU
1634 Gull Rd.
Kalamazoo, 49001

Lawrence G. Talbot, MD OPH
2917 Vinsetta
Royal Oak, 48073

Farouk S. Tootla, MD CRS/GS
909 Woodward Ave.
Pontiac, 48053

Bruce L. Van Cleave, MD FP
260 Jefferson, S.E.
Grand Rapids, 49503

Gerald E. Van Wieren, MD IM
701-05 Cherry Lane
East Lansing, 48823

Thomas L. Van Wingen, MD OBG
201 Russwood, N.E.
Grand Rapids, 49505

HSA
Health Systems Agencies
The Challenge To Medicine

MSMS has HSA slide-tape show

The MSMS Physician/HSA Support Center has a new 13-minute slide/tape show designed to explain the health planning process and to answer the most common questions raised by physicians. The presentation is available for county medical society, auxiliary and hospital staff meetings. The slide/tape show can be presented independently or as a 'trigger' film to initiate discussion conducted by a physician or MSMS staff member. To reserve this presentation for your meeting, please contact Dennis Paradis, MSMS Physician/HSA Support Center, 120 W. Saginaw, East Lansing, 517/337-1351.

25 YEARS Experience Managing Group Insurance Programs

Disability Income Protection, Life Insurance Coverage, Business Overhead Insurance, Special Accident Insurance. . .

For the past quarter century Stratton-Cheeseman and Associates has been serving Michigan State Medical Society members, saving you money and offering the kind of high quality, competitive products necessary to meet your insurance needs. Contact us for further information about disability income protection, life insurance, business overhead disability coverage, special accident insurance. . . for all your insurance needs, for you and for your employees. Call toll free 800/292-1966.

Stratton-Cheeseman & Associates, Inc.

P.O. Box 1563, 1305 Abbott Road East Lansing, Michigan 48823
Phone: 517/351-5780

The Michigan hospice MD

By Eileen McMahon, RN, Lansing

In June, 1980, *MICHIGAN MEDICINE* featured the hospice as an innovative and supported alternative to medical care. The following article is an update on the growth of the concept, physician involvement and legislation in Michigan.

The current use of the term "hospice" describes a centrally administered program of palliative and supportive services providing physical, psychological, sociological and spiritual care for the terminally ill. The patient and the family are the primary unit of care, and services are provided by an interdisciplinary team of professionals and trained volunteers. The medical direction of the hospice program is provided by a physician.

For physicians and patients, the hospice alternative offers the hope that when prolonging life no longer is possible or appropriate, quality of life will be supported. It offers the belief that medical attention need not cease with the determination of an incurable disease.

Andrew D. Hunt, Jr., MD, coordinator, Medical Humanities Program, Michigan State University, supports the hospice movement and medical care specifically for the terminally ill. At the same time, he recognizes the conflicts created by medical education's orientation, current practice and the skills needed to care for a dying person.

"Scientific medicine is disease-oriented, researching and solving disease problems," he says. "Traditional medicine revolves around this. In practice, care is oriented toward treating diseases, as opposed to persons. 'Dehumanization' is a result. Success is cure, not solving is failure, death is failure.

"The hospice situation involves a completely different approach. The primary concern is the well-being of the patient as opposed to the disease."

Doctor Hunt adds that medical ethics seminars and discussions on death and dying are becoming popular in medical schools, although largely limited to the more progressive schools. Educational opportunities for preparing physicians in the medical management of a hospice will hinge on existing programs in Michigan, the United States and Europe.

Charles O'Shaughnessy, MD, Hospice of Southeastern Michigan, is pleased with the success of the program since it began accepting patients in October. Located in Southfield, northwest of Detroit, the 42-bed inpatient facility was founded by a group of major hospitals in the Detroit Metropolitan area.

"We're finding that a lot more can be done for the dying," he says. "Dying is a process: we offer intensive medicine of a special kind, where human contact is to the dying, as an appendectomy is to appendicitis."

Doctor O'Shaughnessy dispels the notion that a hospice is a place of doom. "It's the exact opposite. There's more genuine joy and laughter here, than in any other clinical situation I have ever been in. Maybe it's the frankness. Even though the time is rough, it's a little less rough."

Grand Traverse Area Hospice offers comprehensive care to terminally ill patients primarily in the home setting. Judith Ramsdell, MD, oncologist, sees her position in hospice care largely as consultant. "I see patients less, due to the good medical care and home care by the nurses and volunteers."

Doctor Ramsdell emphasizes the need for quality communication.

The protocol for care for th dying person is not as defined as th regime used for treating a pulmonar embolus," she says.

"You have to take the time. Yo have to listen to a patient's need first, and then you care for them individually. Honesty leads to honest and communication is best."

Communication is important a the community level, too, accordin to Heidi Joos, MD, Hospice of Lansing. She describes the attitude o community physicians as "cautiou skepticism." "Until hospice is estab lished in a community, the ac ceptance of this type of care b physicians must first answer basi questions such as, 'What's hospice a about?' 'What are they (hospice going to do?' Some physicians fe threatened. Some referring phys cians prefer the hospice to offer minimal degree of care. Others wa the team to take over total medic management."

The role of the hospice physicia varies between programs and stru ture of care. Physicians common act as consultants, referring agent team-evaluators and palliative med cal managers. As an integral part the interdisciplinary team, the phys cian offers medical care decisio coordinated with the input of oth areas of expertise.

A state law passed in Octobe defines hospice and necessitat licensure and certificate of need. T Michigan Hospice Organization w supply the first draft of certificat of-need principles and criteria to t Michigan Department of Publ Health.

The Michigan Hospice Organiz tion and the Michigan Department Public Health will be working close together to write licensure standar and rules for program operation.

Michigan State Medical Soci Liaison Committee with the MD has submitted names of two Way County physicians, Philip Malon MD, and William Simpson, MD, the MDPH, for the committee's w with the Department in develop hospice rules and regulations. MS has joined the Wayne County Me cal Society in endorsing the hosp concept and in encouraging phy cians to participate in hospice p grams.

Ms. McMahon is editor of the newsletter of the Michigan Hospice Organization.

Michigan Governor William G. Milliken has designated April 5-11, 1981, as Michigan Hospice Week. The Michigan Hospice Organization and nearly 40 developing and operating hospice groups across the state will focus on educational and fund-raising programs in hospice communities.

Self-insurance saves you money, but it needs the care of a money manager.

Many hospitals have found significant savings in self-insuring their malpractice coverage. In fact, in-hospital coverage of workmen's compensation and other employee benefit programs such as dental, health, disability and group life insurance has dramatically increased the use of self-insurance in medical institutions.

Proper administration of a self-insurance program, however, needs the services of an experienced investment manager, Detroit Bank & Trust.

We've served Michigan residents for over 130 years and rank as one of the largest trust institutions in the midwest. Our outstanding record as a manager of fixed income securities and our extensive experience in administering employee benefit programs have led many hospitals to choose us as their investment manager for self-insurance plans.

If you would like more information on how we can help you with your self-insurance or employee benefit programs, call or write Terry Keating, Vice President, at (313) 222-3898, Detroit Bank & Trust, Box 59, Detroit, Michigan 48232.

Self-insurance is not your most important job, but managing your money better is ours.

DETROIT
BANK
& TRUST

Member FDIC

Principal Trust Offices in
Detroit • Birmingham • Gaylord

Mr. Terrence E. Keating, Vice President
Detroit Bank & Trust
Post Office Box 59
Detroit, MI 48232

Please contact us in regard to administering our self-insurance program.

Name______________________Title______________

Hospital______________________________________

Address_______________________________________

City____________________State__________Zip__________

Telephone____________________

MEDICAL NEWSFRONTS

Myasthenia gravis research at Wayne State University School of Medicine has been boosted with a $5,000 grant from the local Myasthenia Gravis (MG) Association to study the disease of the neuromuscular system. The grant has been made to Helene C. Rauch, MD, WSU associate professor of immunology and microbiology, whose laboratory has been designated the MG Treatment Center Laboratory for Research.

Doctor Rauch and her colleagues are working to develop an effective, inexpensive blood test to determine the level of antibodies produced by the victim of MG. This test will be used to diagnose and monitor the disease, as well as to evaluate treatments for MG. In addition, it will be a tool used for investigating the causes of the disease.

Doctor Rauch's studies will be conducted in conjunction with the Detroit MG Treatment Center, directed by neurologist Doctor Raina Ernstoff, and located in Sinai Hospital since its opening January, 1980.

Six additional cases of Reye's Syndrome were reported between Jan. 27 and Feb. 26 to the Michigan Department of Public Health. None reached stage 3 or greater before or during hospitalization. Five cases had a respiratory illness prodrome, the sixth a chickenpox prodrome. To date there have been no deaths.

The State of Ohio has received 12 reports of Reye's Syndrome cases since the first of the year. Indiana and the Province of Ontario have received reports of six cases each in the same time period. Minnesota and Wisconsin have reported one case each.

Rubella prevention is the subject of a recent Michigan Department of Public Health "Circular" newsletter. The "Circular" reports the Feb. 6 issue of the Center for Disease Control's "Morbidity and Mortality Weekly Report" contains the most recent statement of rubella prevention from the Advisory Committee on Immunization Practices.

While pregnancy remains a contraindication to vaccine use, its inadvertent administration to women who are pregnant or who shortly become pregnant is no longer considered a reason to recommend interruption of pregnancy. Experience with the RA 27/3 strain introduced in January 1979 has added to the observations made with earlier vaccine strains that the risk of serious congenital malformations is very small, if indeed there is any risk at all.

For these safety reasons, as well as morbidity trends showing most wild virus disease occurring in persons over 15 years of age, we are encouraged to place increased emphasis on vaccinating susceptible adolescent and adult females of childbearing age, especially in military services, colleges and universities, and among employees of hospitals and clinics.

Such a policy, coupled with the now routine immunization of prepubertal groups, offers the best chance of both reducing the chances of epidemics as well as conferring individual protection against rubella-induced fetal injury among the persons most likely to bear children during the next decade.

A drug that prevents clotting of the blood can slow the growth and spread of cancer, says a report in the Feb. 27 *Journal of the American Medical Association*.

A Veterans Administration Cooperative study tested the premise that warfarin sodium, an anti-clotting drug, would modify the course of cancer. The study found that the drug doubled the survival time of individuals with one type of lung cancer, says Leo R. Zacharski, MD, of the VA Medical Center, White River Junction, Vermont.

The warfarin sodium was added to the treatment program of drugs plus radiotherapy for 25 patients with small cell carcinoma of the lung. These individuals had a me dian survival time of 50 weeks. A control group of another 25 individ uals with the same type of cance who received drug and radiatio therapy without the anti-coagulan recorded a median survival time o 24 weeks, Doctor Zacharski said.

More older Americans are retirin and moving to the Southwester sunbelt to escape the rigors of nort ern winters. And some of those olde Americans are developing maligna melanoma, a particularly viruler type of skin cancer caused by to much sun.

Michael M. Schreiber, MD, o Tucson, Ariz., reports that incidenc of malignant melanoma has been i creasing during the past 10 year with a very high rate in souther Arizona. There were 20 maligna melanomas reported in souther Arizona in 1969. The figure climbe to 120 in 1978, and the increase f the 10-year period was 340 percen Doctor Schreiber says.

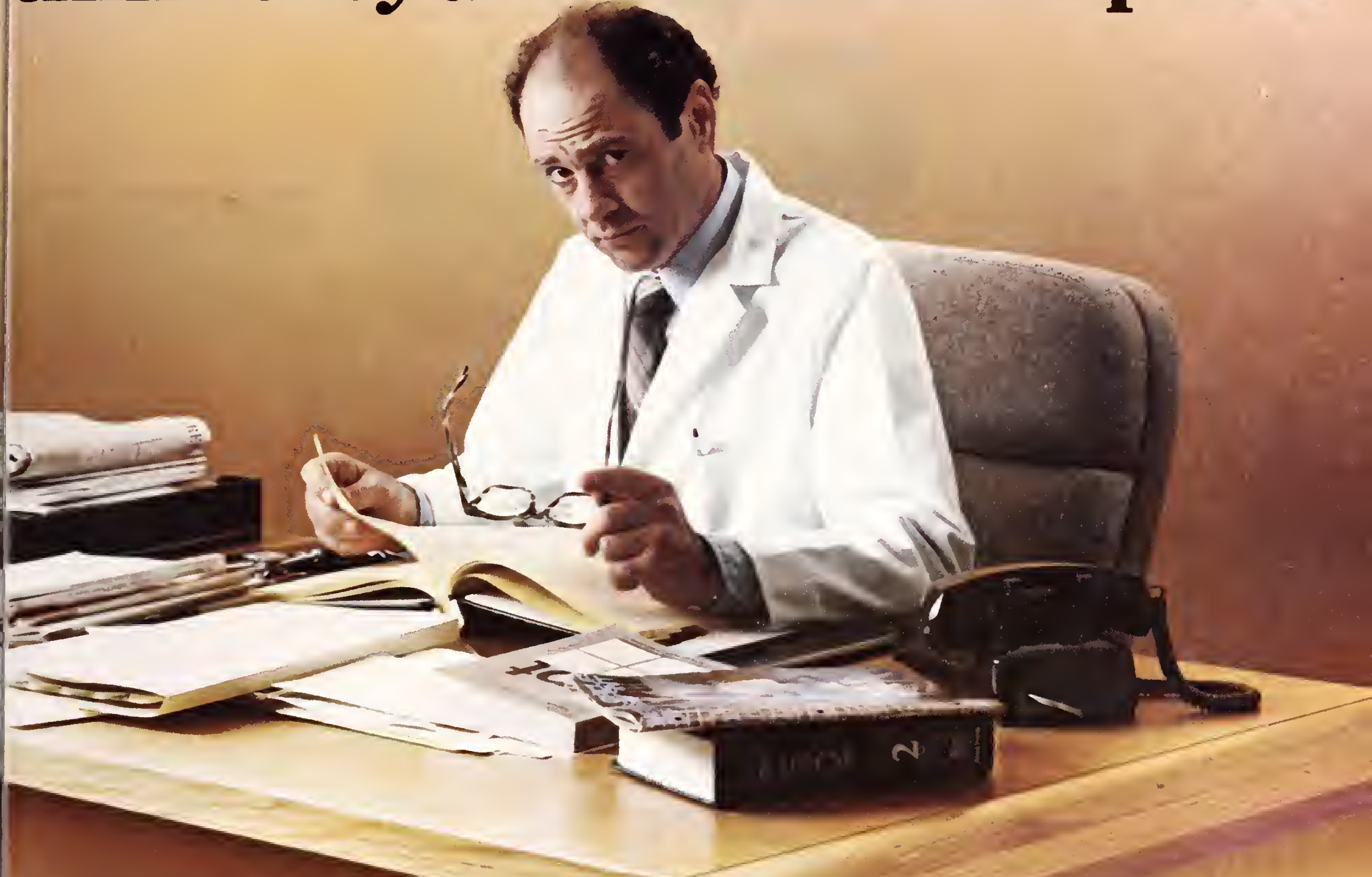
Writing in the January *Archiv of Dermatology*, a journal of th American Medical Association, th Arizona doctor reports that mali nant melanoma is primarily a sk problem for fair-skinned whites.

Dark-skinned whites, Latins, I dians and blacks have relatively litt problems from skin cancer.

Laetrile checks out as safe, says a r port in the Feb. 13 *Journal of t American Medical Association*.

The report is the first phase the National Cancer Institute's test humans of amygdalin, or laetri under direction of the Mayo Clin Rochester, Minn. The first phase volves evaluation of the chemic properties and potential safety of t product. Next phase will be a test humans of possible anticancer act ity.

We're looking for doctors who think they don't need a computer.



Because they think a computer is too expensive.

The Sequoia Medical System™ can pay for itself:

- Increased collections
- Decreased receivables
- Improved staff efficiency

Because they think they already have firm control of their billing.

The Sequoia Medical System automatically processes billing paperwork:

- Patient statements
- Third party claims
- Collection letters

Because they think they have easy access to vital practice data.

The Sequoia Medical System provides information immediately:

- Aged receivable reports
- Procedure and diagnosis analysis
- Daily production and revenue analysis
- On-line access to 4½ million medical journal articles in the National Library of Medicine
- And many other forms of essential data

Because they think a computer is administratively disruptive.

The Sequoia Medical System is designed to blend smoothly into solo and small group practices:

- Easy to use
- Pre-programmed, turn-key system
- Includes training, installation, local service and support.

Because they haven't seen a Sequoia Medical System.

Sequoia can provide more time for health care in your practice. While it's taking care of business . . . you're taking care of patients.

Start looking into the benefits of a computer today by calling Sequoia Group. Call toll free (800) 227-2360; in California (800) 772-2655 . . . or write for our brochure.

SEQUOIA GROUP™
INCORPORATED
1100 Larkspur Landing Circle, Larkspur, CA 94939
Atlanta, Birmingham, Boston, Buffalo, Charlotte, Chicago, Cleveland, Columbus, Dallas, Denver, Detroit, Hartford, Houston, Indianapolis, Irvine, Kansas City, Los Angeles, Memphis, Miami, Minneapolis, Nashville New Orleans, New York City, Norfolk, Oklahoma City, Philadelphia, Phoenix, Pittsburgh, Portland, Salt Lake City, San Diego, San Francisco, Seattle, St. Louis, Tampa, Washington, D.C

works well in your office...

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.
- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Borgess Hospital has outstanding example of cardiac rehabilitation program

By Martha Boyce, special to Michigan Medicine

Borgess *Hospital Cardiac Rehabilitation Institute patient uses arm weights as part of a maximal* graded exercise test.

Throughout Michigan, the value of extended cardiac rehabilitation is being recognized. Those who have had heart attacks and those who are considered to be high-risk candidates both benefit from such a program.

In Michigan, one of the most outstanding examples of cardiac rehabilitation is found at Borgess Medical Center in Kalamazoo.

Although the four phases of rehabilitation are fairly common, the program at Borgess has two major advantages. First, since all four phases involve monitored exercise within the hospital itself, patients may progress through the phases more smoothly.

Second, Phases III and IV, the risk reduction or extended care phases, take place in the Cardiac Rehabilitation Institute. The Institute, with its gymnasium, classrooms and monitoring facilities, is the first such free-standing facility designed specifically for cardiac rehabilitation within a hospital system in Borgess' knowledge.

E. Enrique Leguizamon, MD is the medical director of the CRI at Borgess. Since joining the staff in 1971, Doctor Leguizamon has been instrumental in the development of the rehabilitation program.

Possibly the country's first inpatient Cardiac Rehabilitation and Exercise Testing Center was established at Borgess in 1975. The separate Cardiac Rehabilitation Institute just opened last year.

Phase I of rehabilitation at Borgess for post-op or heart attack patients begins in the Coronary Care Unit. Exercise specialists come to the patient's bedside and begin moving his arms and legs in simple stretching routines. As the patient grows stronger he begins doing these exercises himself.

After about three days in the CCU, the patient is taken to the intermediate CC floor where he begins walking exercises. The hall is 57 meters long, and when a patient is able to walk two lengths of the hallway he may exercise twice a day at the CR in-hospital unit. Heart rate, EKG and blood pressure are closely monitored during each session. After a low-level graded exercise test, the physician will determine when the patient can go home, and in addition to home exercises, he may order Phase II of the program.

At this stage the patient also receives educational material — pamphlets, movies and personal instruction concerning anatomy and physiology of the heart, heart disease and risk factors. Prior to discharge, a dietician instructs the patient on his diet. This combination of exercise and education marks the first phase of recovery.

During Phase II, the prescribed exercise program is followed either at home, on visits to the CR in-hospital unit, or both. After three or four weeks a maximal, symptom-limited, graded exercise test (GXT) is given. After reviewing this test and others, the physician issues a new exercise prescription for Phase III, which is held in the CRI facility itself.

As Phase III begins, the patient and his family are given a tour of the new building and receive information concerning expected benefits and financial assistance. Patients receive the results of their GXT and meet again with a dietician. Exercise sessions of one to four patients meet three to five times a week.

The time a patient spends in Phase III depends on how his body responds to the program. He will be evaluated every three to six months and given periodic progress reports. After several months of the patient's steady improvement, the physician may recommend Phase IV.

Some of the patients participating in Phase IV are individuals recommended by their physicians for risk reduction, or heart attack prevention. Before starting the program they

CARDIAC/*continued*

are given a GXT and their body fat is measured in a test tank. If they do not meet the minimum exercise level or have some other physical limitation they may be placed in Phase III or a modified Phase IV. This individualized treatment is a valuable feature of all the phases at Borgess.

The exercise sessions in Phase IV involve 15 to 30 patients. They are the same duration as in Phase III, but the 40 minutes is divided into 25 minutes of walking and jogging on the indoor track and 15 minutes of aerobic games such as volleyball, badminton or basketball. Heart rate and blood pressure continue to be monitored during exercise and every six to 12 months patients receive progress reports. They also attend educational seminars together.

One of the new features of Phase IV is the Occupational Functional Stress Test. An attempt is made to recreate the work environment as closely as possible and to measure the body's work performance before the patient actually returns to his job. As part of the follow-up, a Holter monitor may be used to record any rhythm or conduction abnormalities during the first day at work, since certain environmental and psychological settings cannot be duplicated at the Institute. Future plans, however, do include regulation of temperature and humidity in a special environmental chamber.

One concern of hospitals and patients about the four-phase program is the fact that Blue Cross does not cover the last two phases of rehabilitation. At Borgess the cost of Phase III is $17 per section per day. The sections meet two to three times a week for two to three months. Phase IV costs $5/day. These costs are small compared to the $200-$300/day for in-hospital care. Perhaps as more data is provided this change will be forthcoming.

There are currently 250 to 300 patients participating in various phases of rehabilitation at Borgess. Some drive 50 to 60 miles for the Phase IV monitored exercise program.

Through group activity, heart patients are progressing faster because they are encouraged by those farther along in the program. It has been proven that combining groups of varying age and ability has positive results.

Finally, the benefits of exercise itself must be reiterated. As their physical condition improves, patients' fears of being helpless are assuaged. Many patients find they are more active and energetic than before their heart attack.

Cardiac rehabilitation programs like the one at Borgess Medical Center are granting heart patients a new lease on life.

AN ATTRACTIVE ALTERNATIVE TO PRIVATE PRACTICE — AIR FORCE MEDICINE

Did you go to medical school to become a doctor or an office manager, supply clerk, or repairman? If you want to concentrate on your medical practice and leave the administration to someone else, then Air Force medicine can be an attractive alternative to your private practice. You see, the Air Force uses a group practice system of health care. This system allows maximum contact between patient and physician with a minimum of administrative responsibilities. Nurses and technicians take care of the paperwork while you take care of the patients. You'll get to use the skills gained through years of education; to stay abreast of new methods and techniques; and, for qualified physicians, to specialize. These benefits, along with our excellent employment package, make Air Force medicine an attractive alternative to private practice. Find out how you can be a part of the Air Force health care team. We'll answer all your questions promptly and without obligation.

Contact at 23400 Michigan Ave., Village Plaza, Dearborn, MI (313) 561-7018.
In Ann Arbor: (313) 668-2047. In Lansing: (517) 372-3133.

AIR FORCE
A great way of life

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN

Healthy Competition
Makes A Healthier Market

**Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.**

Occurrence Coverage

Choice of limits— $100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

Physicians should be aware of growing use of DMSO

By Kim White, special to Michigan Medicine

Industrial grade DMSO contains impurities and is probably too strong for human use, the Michigan Department of Public Health cautioned the public in mid-March. DMSO could cause serious side effects, if the industrial solvent is used as an arthritis pain reliever, said the MDPH. Previously, a bill, HB 4105, was introduced by Rep. Joyce Symons to legalize the sale of DMSO as a pain killer. It is in the House Committee on Public Health.

DMSO (dimethyl sulfoxide) is a substance growing in medical use. Consequently, physicians are having to take notice.

DMSO is a byproduct of wood processing which, when rubbed into the skin, is quickly absorbed. While many studies have shown that the drug is useful for treating animal muscle aches and pains, in its pure form, the drug has been approved by the FDA for use in treating a painful bladder condition, chronic interstial cystitis, and a rare rheumatic disorder.

There is evidence that most people use DMSO for painful arthritic conditions, and that its topical use is gaining in popularity.

Ironically there are no well-controlled DMSO studies being conducted under investigational new drug applications for the treatment of rheumatoid arthritis or osteoarthritis and no new drug application is before the agency for approval of DMSO for these conditions.

Yet the drug continues to be widely promoted for arthritis by clinics or health centers who administer it topically and even intravenously, and by distributors who sell it cash on delivery to people's homes.

What concerns the FDA and the medical community is that the sale of DMSO is spreading. Selling DMSO is a lucrative business. Anyone can do it. The sale is perfectly legal, as long as they follow FDA guidelines, advertise DMSO only as an industrial solvent, and make no medical claims.

Customers buying the solvent must sign a waiver form that includes a statement by the FDA regarding warnings on the use of DMSO for medicinal purposes.

Two cases of serious reactions to intravenous use of DMSO have been reported in the *Lancet*, an authoritative British Medical Journal, on January 15, 1981.

An elderly couple was reported to have become very ill following DMSO injections to treat arthritic knees. They became ill after the second of three projected injections.

The wife vomited blood and suffered severe kidney damage and a small stroke. Both she and her husband had similar blood abnormalities following their treatments. Some of these abnormalities could have been due to liver damage but other organs may also have been involved.

In October the Arthritis Foundation said that it does not endorse DMSO for arthritis. "What we do endorse is the idea that it might have limited usefulness as a pain reliever. We are urging that necessary testing of this possibility be carried out and an appropriate application be made to FDA for approval of such limited use."

"There is no evidence that DMSO alters the course of any disease, or is, in any sense, a miracle drug," emphasized J. Richard Crout, MD, Director, Bureau of Drugs, Food and Drug Administration, when speaking before the Select Committee on Aging, House of Representatives last year.

But, Doctor Crout said, "No one is denying or being unsympathetic towards the potential of DMSO to provide symptomatic relief for patients with certain painful disorders . . ."

Doctor Crout also added that the Cooperative Systemic Studies for Rheumatic Diseases Group will conduct a controlled and blind trial of DMSO for scleroderma.

"We look forward to receiving the results of this new trial. But I must acknowledge in all honesty that a definitive scientific answer is probably at least two years away," he said.

At present, the FDA has on file 24 active investigational new drug applications (IND's) for DMSO, some sponsored by major firms. Conditions under study include scleroderma, joint injuries and spinal cord injuries.

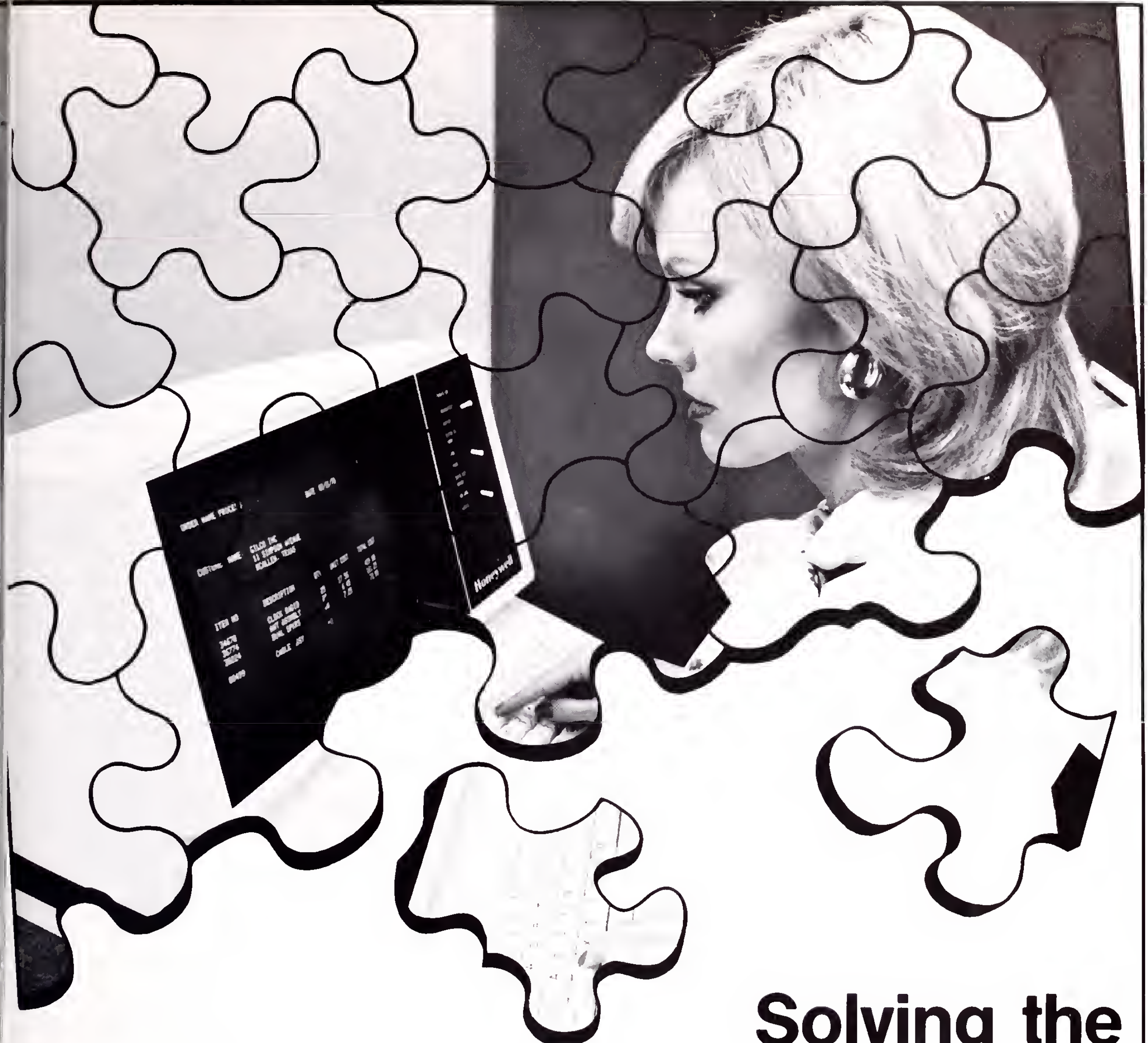
The medical community and regulatory agencies are concerned about the use of the drug as well as the chemical quality and purity of the DMSO which is being distributed.

Meanwhile, the FDA has urged physicians to counsel patients against purchasing DMSO of unknown quality and using it for medicinal purposes which have not shown to be effective.

Physicians also should be alerted to the adverse effects of DMSO, which include erythema, nausea and blurred eye vision or other eye problems.

Physicians with patients afflicted with scleroderma ulcers can use the drug under the investigational drug provisions of the law. They should contact Research Industries Corporation, Salt Lake City, Utah. Phone: 800-453-8432.

Any qualified physician who is interested in participating in a clinical study with the drug can contact Ms. Vicky L. Hunt at: Research Industries Corporation Pharmaceutical Division, 1847 West 2300 South, Salt Lake City, Utah, 84119, (801) 972-5500.



Solving the Computer Puzzle

Purchasing an office computer system can be a time consuming and confusing process. Particularly when it comes to putting together all the "pieces" necessary for a smooth, trouble-free installation.

The Paradata/Honeywell Medical Computer System provides the modern medical office with an economical and productive means of "taking care of the paperwork" by offering the following components:

Hardware: The Honeywell Level 6 is a full function business computer designed to offer the most advanced electronic technology and growth capability available today.

Programming: Years of design and local field testing have been combined to provide a program package tailored to the specific needs of the Michigan doctor.

Training: Knowledgeable representatives will work with your operator until the fundamentals of efficient operations have been mastered.

Service and Maintenance: In-house service is provided by Paradata customer engineers. A periodic maintenance agreement is also available.

In short, our system is complete, installed, and offers all the "pieces" from a single source. It's the system engineered by professionals for professionals.

ParaData
OF MICHIGAN, INC.
3000 Town Center, Suite 2830, Southfield, Michigan 48075
(313) 352-3820

For more information, return completed coupon.

NAME
ADDRESS
CITY STATE ZIP
CONTACT ( ) PHONE

National figures available on health care use, expenditures

By Martha Climo, special to Michigan Medicine

The National Center for Health Services Research (NCHSR) is conducting a study on how Americans use health care services and what the patterns of health expenditures and insurance are. The study is generating a series of analytical reports on critical national health policy issues for government agencies, legislative bodies, health professionals and others concerned with health care policies. Two reports are currently available: "Who Are the Uninsured?" and "Who Initiates Visits to a Physician?"

"Who are the uninsured?"

According to the report, "Who Are the Uninsured?" information was gathered in early 1977 on the civilian, non-institutionalized population, to help determine the extent to which the United States population has private or public health insurance coverage.

The report revealed some of the following information: 12.6 percent of the civilian non-institutionalized population had no health insurance coverage. People from ages 18 to 24 were most likely to be without health insurance. People 65 years of age or older were less likely to be without coverage. No differences in coverage existed between sexes. Large differences existed between whites and all others; non-whites were more likely to be without insurance coverage. Less educated people were more likely to be without coverage. When grouped by residence, rural people were more likely not to be covered. When grouped by region, people in the South and West had the lowest coverage.

Certain family insurance plans often omit some members of the family. Some members are ineligible under many public programs for families. Many private insurance plans offer the option of individual or family coverage.

"Who initiates visits to a physician?"

According to the report, "Who Initiates Visits to a Physician?" "from January 1 to March 31, 1977, about 60 percent of visits to physicians were initiated by patients, while about 35 percent were initiated by physicians through making an appointment with the patient during a previous visit."

The question of who determines whether a visit occurs is important because physician income may be influenced by the number of times patients are seen.

This report reveals not only the relative frequency of physician-initiated and patient-initiated visits, but also reveals clear differences in the respective percentages of visits. More physician-initiated visits were for visits in hospital out-patient departments than for visits in physician offices. Physician-initiated visits for older people were greater than for younger people. Visits for pre- or post-natal examinations were more likely to be initiated by a physician. Patients primarily initiated more visits for eye examinations for glasses.

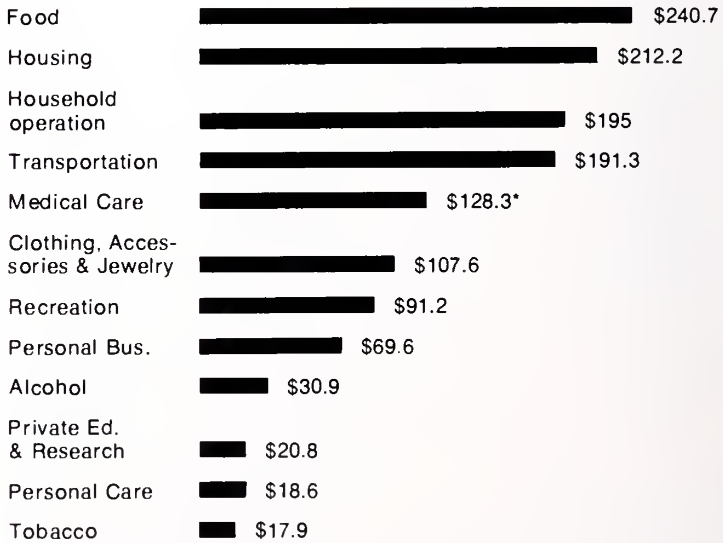
There were no statistically significant differences in the percentage of physician-initiated visits by sex, color or education. The Northeast had a significantly higher percentage of physician-initiated visits than the South.

Some differences existed according to the number of physicians per 100,000 people. Physician-initiated visits rose with the overall physician-to-population ratio.

Visits to physicians also varied according to the type of health insurance coverage. The major statistical difference is between the percentage of physician-initiated visits by the uninsured group and the group covered by private health insurance, and groups covered by Medicare and Medicaid.

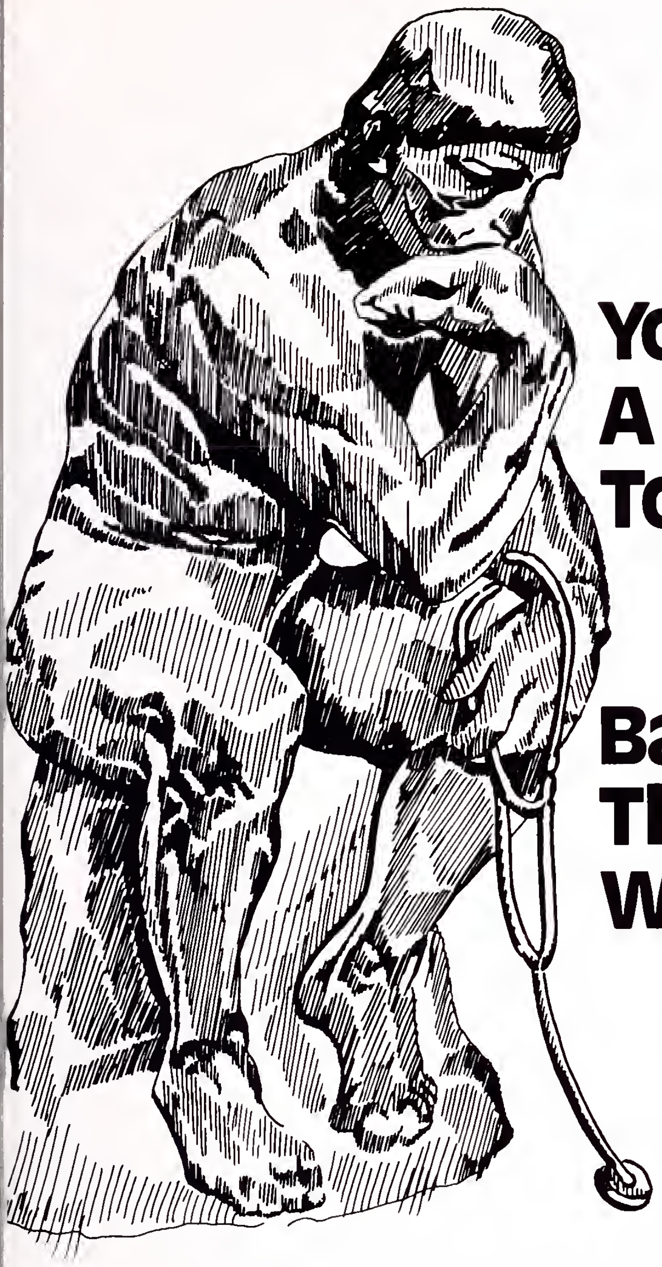
1978 PERSONAL CONSUMPTION EXPENDITURES

Billions of Dollars



*Includes all expenses for health insurance (except loss of income)

Source: U.S. Department of Commerce



You Give A Lot Of Thought To Your Decisions...

Base Your Thoughts On Facts With CRT Systems.

In order to know whether you're making the decisions that will keep your practice operating efficiently, you need factual, understandable information about your accounts receivable activities. But you can't afford to spend your time involved in non-medical matters. That's why you need a computerized management system that provides you with concise, in-depth information about your practice's profitability while freeing you and your staff from non-productive paperwork and accounting functions.

Here's how CRT's Medical Billing and Information System Works.
For a modest monthly charge, CRT will install an easy-to-use terminal in your office. Your transactions are analyzed in various ways to generate insurance forms, claims, reports, billings, statements, service and payment analyses, transaction journals... all the information you need to evaluate and control your business and accurately document all services, charges and payments. And it keeps staff costs down by eliminating redundant work such as typing claims, insurance forms, receipts, day sheets, statements, etc. Start making the right decisions now. **Contact CRT Management Company • 6934 West Fort Street • Detroit, MI 48209 • (313) 554-2330**

CRT
MANAGEMENT
COMPANY

☐ Please send me CRT's Information System Brochure.

☐ Please call me to arrange a no-obligation demonstration of CRT's Information System.

NAME ____________________

ADDRESS ____________________

____

PHONE ____________________

Mail to: **CRT Management Company • 6934 West Fort Street • Detroit, MI 48209 • (313) 554-2330**

MEETINGS

MSMS, MSMS/A, AMA and medical assistants

Apr. 23-25 — 77th AMA Congress on Medical Education and Licensure, Palmer House, Chicago, contact: Department of Meeting Services, AMA, 535 N. Dearborn, Chicago, 60610.

Apr. 23-26 — Annual Meeting, State of Michigan Branch, American Association of Medical Assistants, Hilton Inn, Lansing, contact: Caroline Rich, MSMS headquarters.

Apr. 27-29 — 55th Annual Convention, MSMS Auxiliary, Marriott Inn, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

May 1-3 — MSMS House of Delegates, Troy Hilton, contact: Richard Campau, MSMS headquarters.

May 5-14 — MSMS/Intrav Canadian Rockies Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

July 16-19 — MSMS Council, Grand Traverse Hilton, contact: Warren Tryloff, MSMS headquarters.

Sept. 9 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Sept. 18-28 — MSMS/Intrav Italian Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

Oct. 21 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 17-18-19 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

Apr. 15 — 15th anniversary celebration, Oakland County Medical Society, Oakland County Court House and Troy Hilton Inn, contact: Kenneth L. Urwiller, MD, President, OCMS, 346 Park St., Birmingham, 48009, 313/646-4700.

Apr. 23 — Council Meeting, Michigan Psychiatric Society, Detroit, contact: Helen Schulte, MSMS headquarters.

May 1 — Annual Meeting, Michigan Society of Thoracic Surgeons, Northfield Hilton Hotel, contact: Rodman E. Taber, MD, 30050 Hoover Rd., Warren, 48093.

May 26-28 — 60th Annual Conference, Michigan Public Health Association, Sheraton Southfield Hotel, contact: MPHA, 1407 S. Harrison, Suite 340, East Lansing, 48823.

June 11-12 — Annual Meeting, Michigan Occupational Medical Association, Traverse City Hilton, contact: Charles R. Buck, MD, Medical Officer, Michigan Bell Telephone Co., Detroit, 48226.

July 29-30 — 24th Annual Congress of Delegates meeting, Michigan Academy of Family Physicians, Holiday Inn, Traverse City, contact: Loretta Joyce, Executive Director, MAFP, 416 N. Homer, Suite 107, Lansing, 48912.

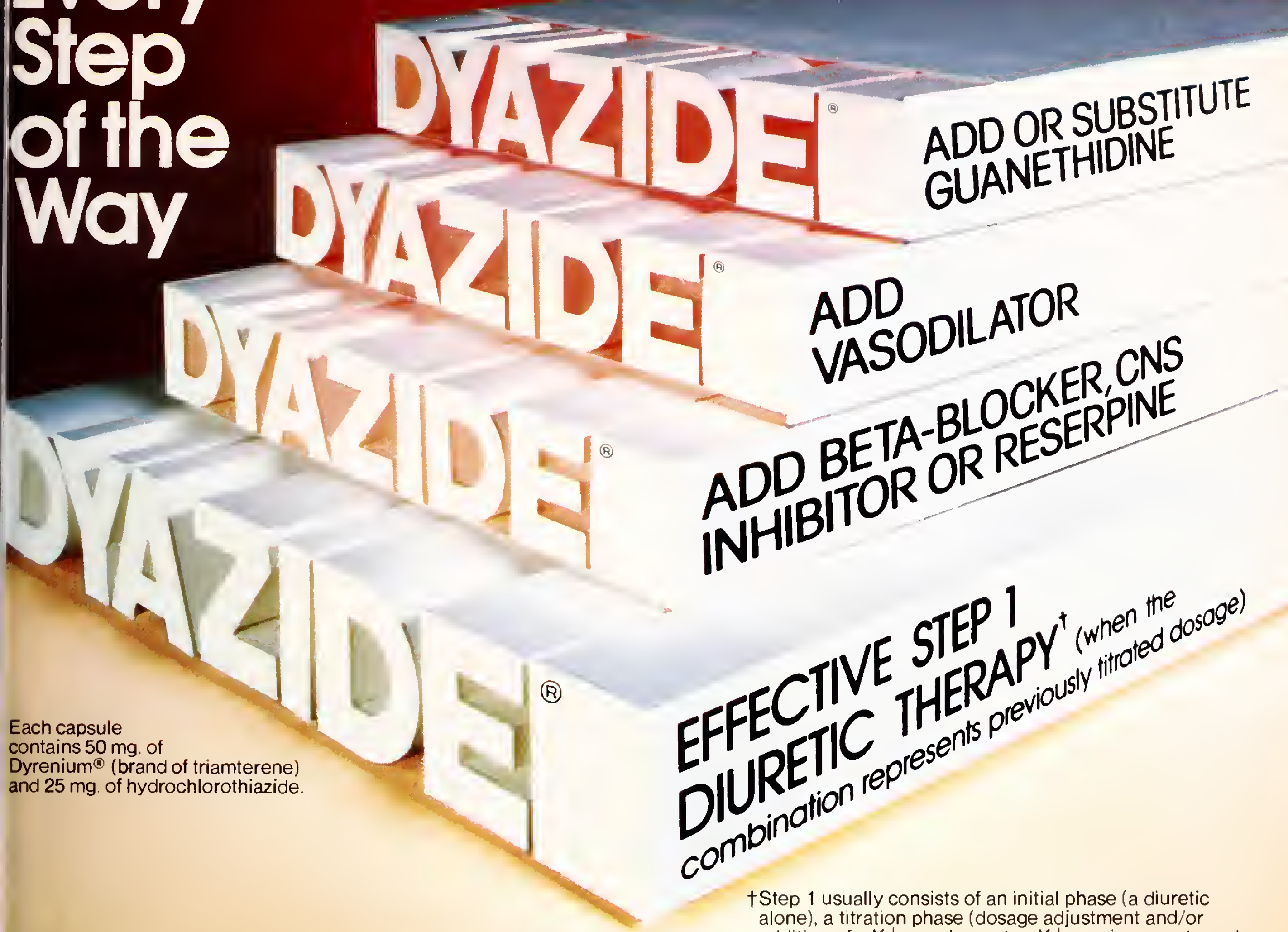
Aug. 28-30 — Summer Meeting, Michigan Psychiatric Society, Holiday Inn, Traverse City, contact: Helen Schulte, MSMS headquarters.

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
Since 1899
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

DETROIT OFFICE
R. K. Wind, J. K. Galloway, T. A. Weisman, and W. M. Bockus, Representatives
6785 Telegraph Road, Suite 350, Birmingham 48010
Telephone (313) 647-6640
GRAND RAPIDS OFFICE: G. J. Howarth, Representative
143 Cortland Avenue, Rockford 49341, Telephone (616) 866-9395

In Hypertension*...When You Need to Conserve K^+

Every Step of the Way


DYAZIDE®
ADD OR SUBSTITUTE GUANETHIDINE
DYAZIDE®
ADD VASODILATOR
DYAZIDE®
ADD BETA-BLOCKER, CNS INHIBITOR OR RESERPINE
DYAZIDE®
EFFECTIVE STEP 1 DIURETIC THERAPY† (when the combination represents previously titrated dosage)

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

WARNING
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual If this combination represents the dosage so determined, its use may be more convenient in patient management Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium Hypersensitivity to either component or other sulfonamide-derived drugs

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency Watch for signs of impending coma in severe liver disease If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored) Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly Antihypertensive effect may be enhanced in post-sympathectomy patients Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine Hypokalemia, although uncommon, has been reported Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

©SK&F Co., 1980

SK&F CO.
a SmithKline company
Carolina, P.R. 00630

Motrin® vs aspirin w/codeine...
(ibuprofen)

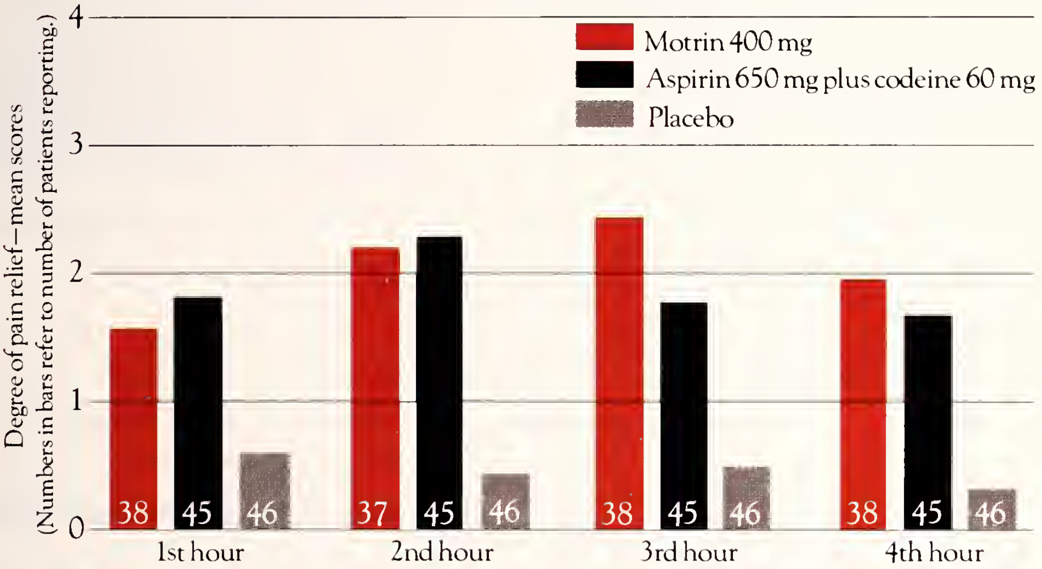
©1981 The Upjohn Company

compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



Time after drug administration (hours)

Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-4-S

J-8260-4

MARCH 1981

WHY I'M A UNITED WAY VOLUNTEER

STEPHEN GRAHAM

Home: Seattle, Washington

Career: Attorney

Age: 29

Married: One daughter

Interests: Hiking, writing, cartooning, bicycling and volunteering for United Way

"Because there's more to my life than just me.

"Like being with my family. Hiking along the timberline. And getting involved in my community.

"Volunteering for United Way adds another dimension to my life. I'm putting my skills to work for the benefit of the entire community. And I'm meeting all kinds of people who are doing the same.

"Most important of all, I'm learning more about human care needs. And how—as a United Way volunteer—I can make a difference here in Seattle. It's a valuable lesson in leadership.

"By helping shape my community's future, through United Way, I'm more than just living my life. I'm fulfilling it."

**Thanks to you...
it works...
for ALL OF US**

United Way

Ad Council A Public Service of This Magazine & The Advertising Council

CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: April 13-17, Family Practice Spring Review and Update. Location: Towsley Center, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical Center. **For:** All interested physicians. **Cost:** $325. **Contact:** Robert P. Means, Ph.D., Towsley Center for CME, University of Michigan Medical Center, Ann Arbor, 48109, or phone 313/763-1423. **Approved for:** 27¼ hours of Category I Credit.

Date: April 15, Pediatric Seminar V. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Office of CME, Saint John Hospital, 22101 Moross Rd., Detroit, 48236. 313/343-4000. **Approved for:** 8 hours of Category I Credit.

Date: April 15, Conference on Adolescent Medicine. Location: St. Lawrence Hospital. **Sponsor:** Michigan State University School of Human Medicine and School of Osteopathic Medicine, Michigan Academy of Family Physicians, St. Lawrence Hospital, and Central Michigan Pediatric Society. **For:** All interested physicians. **Cost:** $25. **Contact:** Andrew Hunt, MD, A110 E. Fee Hall, MSU, 517/355-7550. **Approved for:** 6 hours of Category I Credit.

Date: April 22, The Management of Breast Cancer. Location: Kalamazoo Hilton Inn. **Sponsor:** Borgess Medical Center and Bronson Methodist Hospital's Oncology Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Contact:** Charles L. Zeller, Jr., MD, Director/CME, 252 East Lovell, Kalamazoo, 49007. Phone 616-383-6489. **Approved for:** 4 hours of Category I Credit.

Date: April 22-23, New Directions in Care for the Handicapped Child. Location: Grand Rapids. **Sponsor:** American Academy of Pediatrics. **For:** All interested physicians. **Cost:** $75. **Contact:** Jean Dow, American Academy of Pediatrics, 1-800-323-0797. **Approved for:** 16 hours of Category I Credit.

Date: April 22-24, Computerized Treatment Planning Systems Symposium. Location: Buerki Auditorium, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Cost:** $150. **Contact:** Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 19½ hours of Category I Credit.

Date: April 23-25, Critical Care Symposium. Location: Wayne County Medical Society Headquarters. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Theresa Sokol, WSU School of Medicine, Department of Surgery 6C University Health Center, 4201 St. Antoine, Detroit, 48201. **Approved for:** 15 hours of Category I Credit.

Date: April 25-29, Advanced Muscle Energy Tutorial. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Date: April 27, Orthopaedic Clinic Day. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** Children's Hospital of Michigan, Detroit Institute for Children and Wayne State University. **For:** All interested physicians. **Contact:** Mary Rose Urban, Children's Hospital, Continuing Education Dept., 313/494-5455. **Approved for:** 5 hours of Category I Credit.

Date: April 27-29, Echocardiography — State of the Art. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan Heart Association and the American Heart Association Council on Clinical Cardiology. **For:** All interested physicians. **Contact:** Michigan Heart Association, P.O. Box 160-LV, Lathrup Village, 48076. 313/557-9500. **Approved for:** 15 hours of Category I Credit.

Date: May 6, 1981, Bronson Nephrology Presents: Pathophysiology & Management of Fluid and Electrolyte Problems — With Case Studies. Location: Kalamazoo Hilton Inn. **Sponsor:** Bronson Nephrology. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All general internists. **Cost:** $60. **Contact:** C. L. Zeller, Jr., MD, Director/CME, 252 East Lovell, Kalamazoo, 49007. Telephone: 616/383-6489. **Approved for:** 8 hours of Category I Credit.

Date: May 7-8, Current Perspectives in Ophthalmology: 1981 Spring Conference. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Department of Ophthalmology. **For:** All interested ophthalmologists. **Cost:** $225. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 13½ hours of Category I Credit.

Date: May 9, Testicular Biopsy in Fertility Disorders and Unusual Pathologic Conditions of the Testes and Adnexa. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Michigan Society of Pathologists. **For:** All interested pathologists. **Contact:** Willys F. Mueller, MD, Department of Pathology, Hurley Hospital, Flint, 48502. **Approved for:** 3 hours of Category I Credit.

Date: May 14, Major Problems in Adolescence. Location: Kalamazoo Hilton. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** $55. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 14-16, Cardiac Diagnostic Techniques: A Clinical Perspective. Location: Detroit Plaza Hotel. **Sponsor:** American College of Cardiology, and Wayne State University School of Medicine. **For:** All interested cardiologists. **Cost:** $190 ACC members, $235 non-members. **Contact:** Registration secretary, Extramural Programs Department, American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20014. **Approved for:** 14 hours of Category I Credit.

"Quality" United States & Canadian Decimals Since 1958

CARLTON
NUMISMATICS, INC.

- Professional Numismatic Counseling •
- Acquisition of Rare Coins •
- Portfolio Management •
- Investment Programs •

via
I.R.A., Keogh & Pension and Profit Sharing
Retirement Plans

CAND

CANADIAN NUMISMATIC ASSOCIATION

AMERICAN NUMISMATIC ASSOCIATION ANA MEMBER

To receive your complimentary copy
of our Current Price List and
Descriptive Brochures,
please write or telephone:

Bingham Center • Suite 1646
30700 Telegraph Road
Birmingham, Michigan 48010
313 / 646-8846

BUSINESS HOURS: Wednesday - Saturday 10:00 A.M. to 3:00 P.M. and by appointment.

Life Members A.N.A, C.N.A., M.S.N.S.: Associate Members C.A.N.D.

Pediatricians staging workshops for MDs who treat handicapped children

Michigan pediatricians are taking part in a national effort to educate their colleagues on serving handicapped children.

The Michigan Chapter, American Academy of Pediatricians, is sponsoring two-day, Category I courses to help physicians aid handicapped children in getting their proper education.

The programs in Michigan are funded by a grant from the AAP, which is responding to recent federal legislation mandating that all states meet the special needs of handicapped children to ensure they have equal educational opportunities. A similar Michigan law is even more demanding than the federal legislation.

Donald Waterman, MD, Gran Rapids, was named by the AAP as the physician in charge of Michigan courses. He has teamed with an educator to deliver two workshops so far this year. Two other physician/educator teams are at work in the state, led by Michael Nidiffer, MD, Marquette, and David Benjamins, MD, Detroit.

The Detroit and Marquette-area teams are supported by money provided by the Michigan Board of Education.

Further details are available from Donald Waterman, MD, 220 Cherry St., NE, Grand Rapids, 49503, (616/459-2837).

CATEGORY I/*continued*

Date: May 16, Cytochemical Features of Leukemias. Location: Edward W. Sparrow Hospital, Lansing. **Sponsor:** Department of Pathology, Edward W. Sparrow Hospital. **For:** All interested pathologists. **Cost:** $60. **Contact:** Teresa A. McWilliams, Education Coordinator, Department of Laboratories, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., P.O. Box 30480, Lansing, 48909. 517/483-2530. **Approved for:** 5 hours of Category I Credit.

Date: May 16, Diagnostic Electron Microscopy. Location: Edward W. Sparrow Hospital, Lansing. **Sponsor:** Department of Pathology, Edward W. Sparrow Hospital. **For:** All interested pathologists. **Cost:** $60. **Contact:** Teresa A. McWilliams, Education Coordinator, Department of Laboratories, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., P.O. Box 30480, Lansing, 48909. 517/483-2530. **Approved for:** 5 hours of Category I Credit.

Date: May 16-18, Michigan Dermatological Society Central States Meeting. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Dermatological Society. **For:** All dermatologists. **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hours of Category I Credit.

Date: May 20, Family Practice Update. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 20, Second Annual Regional Medical Conference on Infectious Disease. Location: Southwest Michigan College, Dowagiac. **Sponsor:** Lee Memorial Hospital. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Cost:** $50 for physicians. **Contact:** Judith B. Willis, Assistant Director/Regional Medical Education, SMAHEC, 252 East Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 22, Third Annual Associate Member Meeting. Location: Wayne State University, McGregor Conference Center. **Sponsor:** Michigan Chapter, American College of Physicians. **For:** Internists. **Contact:** Ralph Cushing, MD, FACP, Wayne State Univeristy, 313/577-5084. **Approved for:** 5 hours of Category I Credit.

Date: May 28-30, Medicolegal Investigation of Death. Location: Detroit Plaza Hotel. **Sponsor:** Wayne State University School of Medicine, Department of Pathology and Wayne County Medical Examiner's Office. **For:** Medical examiners, coroners, forensic and other pathologists. **Contact:** Wayne State University School of Medicine, Division of CME, 4201 St. Antoine, 9B-32 DRHUHC, Detroit, 48201, 313/577-1180. **Approved for:** 15½ hours of Category I Credit.

Date: June 1-5, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

Date: July 9-12, Eighth Annual Michigan Emergency Medicine Assembly. Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Chapter, American College of Emergency Physicians. **For:** All interested physicians. **Contact:** Catherine C. Sleicher, Executive Director, Michigan Chapter, ACEP, 1305 Abbott Road, Suite 102, East Lansing, 48823. 517/332-6500. **Approved for:** 26 hours of Category I Credit.

Date: June 15-19, Basic Principles of Manual Medicine. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 19-21, Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Benjamin Henig, MD, Keyport Clinic, 308 Michigan Ave., Grayling, 49738. **Approved for:** 12 hours of Category I Credit.

Date: June 19-21, Michigan Dermatological Society Annual Meeting. Location: Renaissance Center, Detroit. **Sponsor:** Michigan Dermatological Society. **For:** All interested dermatologists. **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hours of Category I Credit.

Date: July 26-29, 13th Annual Summer Conference. Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Opthalmological Society. **For:** All interested opthalmologists. **Contact:** Philip C. Hessburg, MD, 15401 E. Jefferson, Grosse Pte. Park, 48230. **Approved for:** 8 hours of Category I Credit.

Date: Aug. 18-21, Michigan Health Officers Association Annual Meeting. Location: Holiday Inn, Traverse City. **Sponsor:** Michigan Health Officers Association. **For:** All interested physicians and health officers. **Contact:** William W. Moon, MD, Box 43, Harrietta, 49638. **Approved for:** 5 hours of Category I Credit.

Date: Sept. 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, and the University of Michigan Medical Center. **For:** All interested physicians. **Contact:** Robert P. Means, Ph.D., Towsley Center for CME, University Medical Center, Ann Arbor, 48109, or phone 313/763-1423. **Approved for:** 16 hours of Category I Credit.

Date: Oct. 11-15, 1982, Abortion: Spontaneous and Induced. Location: Maui Surf Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1011. **Approved for:** 29 hours of Category I Credit.

EMERGENCY MEDICAL POSITIONS

Emergency Consultants, Inc. has select opportunities in emergency medicine available to accommodate professional and personal physician goals, providing:

- Resort and Metropolitan Settings
- Recreational and Cultural Locations
- Modern Equipment and Accredited Facilities
- Competent Professional Back-Up
- Excellent Benefits with Malpractice Insurance
- Competitive Salaries

Emergency Consultants, Inc. is a physician-owned and operated corporation currently servicing 60 hospitals in 12 states. Our organization offers flexible scheduling and professional growth. Join our group and grow with us.

For further information contact: Emergency Consultants, Inc., Suite 115, 2240 South Airport Road, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

Administrative office
and main laboratory

AMRC the full service laboratory

- Complete range of individual tests and diagnostic profiles
- Medical consultation services
- Comprehensive quality control program
- Fully accredited
- Complete billing service

ADVANCE MEDICAL &
RESEARCH CENTER, INC.

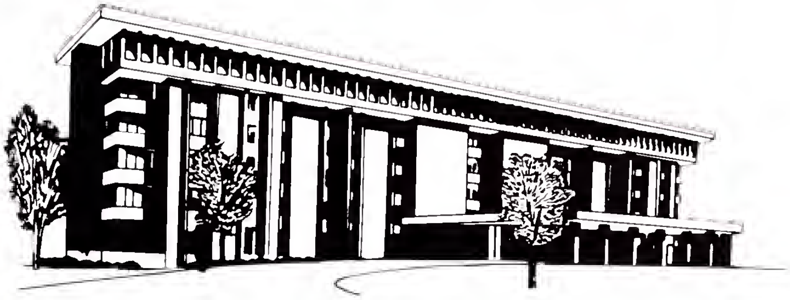
1270 Doris Rd. • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

STAFF PHYSICIAN NEEDED

Family Practitioner or Internist Full Time Position
At Kent Community Hospital, A Community Based
Chronic Disease and Rehabilitation Center.



For Further Information Contact:
Kent Community Hospital
Medical Director
750 Fuller, N.E.
Grand Rapids, MI 49503
Phone (616) 774-3366

KENT
COMMUNITY
HOSPITAL COMPLEX

U.S. ARMY MEDICAL CAREER OPPORTUNITIES

We are looking for physicians who want to be physicians. We offer a practice that's practically perfect, where you work without worrying whether the patient can pay, without endless insurance forms, malpractice premiums, and cash flow worries, and where you prescribe, not the least care, not the defensive, but the best. If that is what you want, join the physicians who have joined the Army. Write us or call collect for the following information. We can offer:

Specialty Assignments
Residencies
Fellowships
Internships
Health Professions Scholarships
Employment Opportunities

Captain Gerard Indrisano
AMEDD Procurement Office
Federal Bldg.
200 E. Liberty St.
Ann Arbor, Mi 48107
(313) 668-2190

DEATHS

Thomas D. DeLawrence, MD
Allen Park

Thomas D. DeLawrence, MD, Allen Park, died Feb. 14 at the age of 76. He earned his MD from the Hahnemann Medical College in Philadelphia in 1949. A specialist in obstetrics and gynecology, Doctor DeLawrence practiced in Dearborn from 1950 until his retirement in 1973. He served on the staffs of Oakwood Hospital in Dearborn and Grace Hospital in Detroit.

Michael Faber, MD
Benton Harbor

Michael Faber, MD, Benton Harbor, died Jan. 23. He was 76. Doctor Faber received his MD from Wayne State University School of Medicine in 1931. He served on the staffs of both Mercy and Memorial hospitals and, from 1941 through 1978, maintained a private practice in Benton Harbor.

A. Morgan Hill, MD
Grand Rapids

A. Morgan Hill, MD, Grand Rapids, died Jan. 17 at the age of 78. He received his MD from the University of Vermont in 1926. Doctor Hill was former chief of staff at Blodgett Hospital and also served there as chief of pediatrics. He was one of the founders and past presidents of the West Michigan Pediatrics Association. Doctor Hill had practiced in the Grand Rapids area from 1927 until his retirement in 1976.

Frank V. Hodges, MD
Tulsa, OK

Frank V. Hodges, MD, Tulsa, OK, died Jan. 20. He was 53. Doctor Hodges earned his MD from the University of Virginia Medical School in 1953. He was a member of the Michigan Society of Pathologists, the Michigan Association of Blood Banks, a fellow of the American Society of Clinical Pathologists and a fellow of the International Academy of Pathology. Doctor Hodges was a clinical professor of pathology at Michigan State University College of Human Medicine and director of laboratories at Hurley Medical Center.

Arthur A. Humphrey, MD
Battle Creek

Arthur A. Humphrey, MD, Battle Creek, died Feb. 10 at the age of 76. He received his MD from Northwestern University in 1928. Doctor Humphrey served on the American Cancer Society's state Executive Board, was subchairman of the original cancer committee of the Michigan State Medical Society and was a longtime member of the Executive Board of the Calhoun County Unit of the American Cancer Society. In 1959, he received the American Cancer Society's highest individual award, the Tiffany Medal, in recognition of his "important control of cancer." Doctor Humphrey was a past president of the Michigan Pathological Society and the Calhoun County Tuberculosis Association.

Stanley James Joyce, MD
Delray, FL

Stanley James Joyce, MD, Delray, FL, died Feb. 3. He was 83. Doctor Joyce earned his MD from the University of Michigan Medical School in 1922. During World War II he served as Commander and Chief of Dermatology at the Annapolis Naval Academy. He was a member of the Detroit Dermatological Society and the American Academy of Dermatology.

James T. Keyes, MD
Birch Run

James T. Keyes, MD, Birch Run, died Jan. 18 at the age of 61. He received his MD from Marquette University School of Medicine in 1944. He served as past president of the Saginaw Academy of Family Practice and as past secretary of the Saginaw County Medical Society. He also served as former chief of staff at St. Mary's Hospital.

Raymond J. Kokowicz, MD
Grosse Pointe Woods

Raymond J. Kokowicz, MD, Grosse Pointe Woods, died Feb. 2. He was 72. Doctor Kokowicz earned his MD from Wayne State University School of Medicine in 1933. He was a fellow of the American College of Cardiology and a member of the American Heart Association. He served on the staffs of St. John and Holy Cross hospitals.

Francis L. Lam, MD
Battle Creek

Francis L. Lam, MD, Battle Creek, died Jan. 29 at the age of 67. He received his MD from the University of Michigan Medical School in 1940. In 1945, Doctor Lam received the Croix de Guerre from the French government for his work in giving medical aid to French civilians. He was a past president of the Calhoun Medical Society and a member of the American Academy of Family Physicians.

Maurice J. Lieberthal, MD
Ironwood

Maurice J. Lieberthal, MD, Ironwood, died Jan. 19. He was 89. Doctor Lieberthal earned his MD from the University of Michigan Medical School in 1922. A former City of Ironwood health officer, Doctor Lieberthal was an organizer of the cancer and heart organizations of Gogebic County. He maintained a private practice in Ironwood since 1925.

Frederic E. Simpson, MD
Muskegon

Frederic E. Simpson, MD, Muskegon, died Jan. 31 at the age of 65. He received his MD from the University of Iowa in 1941. Doctor Simpson served as medical director for the Muskegon County Development Center. He maintained a private practice in Muskegon from 1969 until his retirement in January of 1981.

John S. Sluyter, MD
Holland

John S. Sluyter, MD, Holland, died Jan. 28. He was 66. Doctor Sluyter earned his MD from the University of Michigan Medical School in 1940. He was a member of the American Academy of Family Physicians and served as staff doctor at Kent Community Hospital.

Everette M. Steffes, MD
Troy

Everette M. Steffes, MD, Troy, died Jan. 25 at the age of 72. He received his MD from Loyola University Medical School in 1932. Doctor Steffes maintained a private practice in Berkley from 1948 to 1976. He was affiliated with Providence and Mt. Carmel Mercy hospitals.

Wayne State University School of Medicine Alumni Association 113th Medical Alumni Reunion Day

Wednesday, May 20, 1981
Michigan Inn
Southfield, Michigan

TOPIC:
Medical Trends in the '80s

REGISTRATION:
8:30 a.m.-9:00 a.m.

FEES:
$20.00 for WSU Medical Alumni Association members
$45.00 for non-members

MORNING SESSIONS:
9:10 a.m.-10:00 a.m.
"Free Standing Medical Care Facilities and Satellite Facilities"
10:00 a.m.-10:15 a.m.
Panel Discussion
Coffee Break
10:30 a.m.-11:10 a.m.
"Medical Office Computers"
11:10 a.m.-11:40 a.m.
"Clinical Care in Relationship to the Michigan State Medical Society"

LUNCH:
11:40 a.m.-1:30 p.m.
(Compliments of Parke-Davis Co.)
Presentation of student and distinguished alumni awards
Annual business meeting

AFTERNOON SESSIONS:
1:30 p.m.-2:00 p.m.
"The Present and Future Expectations of Chemotherapy"
2:00 p.m.-2:30 p.m.
"The Present Use and Future Prospects of Interferon"
2:30 p.m.-3:00 p.m.
"The Present Use and Potential for Laser in Disease of the Eye"
3:00 p.m.-3:30 p.m.
"The Use of Laser in Gynecologic Disorders"
3:30 p.m.-4:00 p.m.
"Calcium Blocker — The Successor to Beta Blocker"
4:00 p.m.-4:15 p.m.
Panel Discussion

EVENING PROGRAM:
$65.00 — couple
$32.50 — single
6:00 p.m.-7:00 p.m.
Reception
7:00 p.m.
Dinner, Presentation of Gold and Silver Anniversary Certificates
Dancing and entertainment will follow

5 hours of CME credit in Category 1.
For further information, call WSU
School of Medicine (313) 577-1495.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

MEDICAL ONCOLOGY FELLOWSHIP. Currently available for 1 or 2 years at the Edward W Sparrow Hospital, Lansing, Michigan. Emphasis on clinical training with research opportunities, including work in interferon trials. Prefer applicant who has completed 2 years of internal medical training. Send curriculum vitae to: Francis A. Breen, Jr., MD, Director of Medical Oncology, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, Michigan 48909. A Non-Discriminatory Affirmative Action Employer.

A 600 BED MID-WESTERN COMMUNITY TEACHING HOSPITAL with major medical school affiliation seeks a director of pediatric education. The program includes 12 pediatric residents, four neonatal fellows, rotating flexible and family practice residents and 40 third and fourth year medical students. Candidate should be certified in pediatrics and preferably have subspecialty fellowship training. Salaries and benefits competitive. Submit curriculum vitae to: Box 16, Michigan State Medical Society, 120 W. Saginaw St., East Lansing, MI 48823.

AMERICAN RED CROSS BLOOD SERVICES, Flint Region, is seeking a part-time Medical Director, qualified Hematologist or Pathologist, approximately six hours per week, salary negotiable. Flint location. Interested persons should send complete curriculum vitae to Red Cross, P.O. Box 333, Flint, Michigan 48501, attention Doctor William Macksood. An Equal Opportunity Employer.

CALIFORNIA: Anesthesiologist wanted in Northern California fee-for-service practice located in Marysville. Area is within easy driving distance of Lake Tahoe, ski and recreation areas, Sacramento and the San Francisco Bay Area. Great year-round climate with still reasonably priced homes. Modern, progressive, well-equipped hospital with growing medical staff. Attractive relocation incentive. Contact Judy Neal, 440 Grand Avenue, Suite 500, Oakland, CA 94610, 415/832-6400.

EMERGENCY PHYSICIAN — Full time position in busy ED of full service hospital with excellent physician backup. 40 hour week average, paid malpractice coverage, paid vacation, and other cash fringe benefits. Send CV to Medical Director, Emergency Care Center, P.C., 200 Jefferson, S.E., Grand Rapids, MI 49503.

FAMILY PHYSICIAN TO JOIN two Board Certified family physicians and one physician's assistant in a young and growing medical practice in central Minnesota. The practice is oriented toward family medicine. The practice is located centrally in the state with quick access to Minneapolis/St. Paul. Cultural and recreational activities are in abundance in this area of Minnesota. Salary open: Contact Daryl G Mathews, Adm., or Thomas J. Newton, MD, at the Cold Spring Medical Clinic, 26 N. Red River Ave., Cold Spring, MN 56320. Call 612-685-8641.

OBSTETRICS AND GYNECOLOGY — Grad Year II — Unexpected opening July 1, 1981 in fully accredited 4 year program in large community teaching hospital. For information call or write Dept. of Health Educ., St. John Hospital, 22101 Moross Rd., Detroit, MI 48236. 313-343-3875.

WANTED: Primary physician or surgeon to join busy family and industrial practitioner. Fully equipped office, maximum para-medical assistance including P.A. Finances open, immediate housing available. Phone 313-329-3555 or 982-5165.

FORT WAYNE, INDIANA — EMERGENCY DEPARTMENT PHYSICIANS. American Medical Services Association, Inc., a Kansas City based multiple hospital physician group, is seeking career oriented primary care and emergency care physicians who are: board eligible or certified, show an affinity for the team concept of medical practice, business oriented, show professional maturity and judgment, have a keen desire to succeed, committed to CME. We are successful because we offer the unique package of salary and benefits in the health care industry. All of our physicians participate in the ownership of the company. If you feel qualified, we are interested in you. Contact: Michael P. Colucci, Vice-President of Marketing and Recruitment, American Medical Services Association, Inc., 4400 Broadway — Suite 306, Kansas City, Missouri 64111. 816-931-3040.

ONCOLOGY FELLOWSHIP — 1 or 2 year program in 550 bed teaching community hospital with fully approved residency programs in internal medicine, general surgery, ob/gyn, pediatrics and pathology. Requirements: Completion of 3 year internal medicine residency. For information contact Dept. of Health Educ., St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

NEPHROLOGY FELLOWSHIP — 1 or 2 year program in 550 bed teaching community hospital with fully approved residency programs in internal medicine, pediatrics and general surgery and 16 station out-patient esrd. Requirements: Completion of 3 year internal medicine residency. For information contact Dept. of Health Educ., St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

NEUROSURGERY FELLOWSHIP — 1 year program in 550 bed teaching community hospital, a designated trauma center, with fully approved 5 year general surgery residency. Requirements: Completion of neurosurgery residency. For information contact Dept. of Health Education, St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

CALIFORNIA-DIRECTOR POSITIONS AVAILABLE. Emergency medicine physicians needed for rural Northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit-sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610. 415/832-6400.

FAMILY PRACTITIONERS. Opportunity available in Edmore, northeast of Grand Rapids, Michigan. Financial assistance available to establish practice. For details, send curriculum vitae, or call collect Recruitment Director, Adventist Health System North, 15 Salt Creek Lane, Hinsdale, Illinois, 60521, 312/920-1100.

OB/GYN PARTNERSHIP — Young ob/gyn located in Southern Illinois, with an expanding practice, needs a partner. This pleasant community is family oriented, with good schools and a new hospital. All replies will be kept confidential, send to Box 14, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

GENERAL PRACTICE FOR SALE — Flint, Michigan, due to retirement. Office for one or two doctors available immediately. Grossing in 6 figures. No ob. No medicaid. Replies to Box 15, MSMS, 120 W. Saginaw, East Lansing, MI 48823.

PEDIATRIC RESIDENCY — Grad Year II — Unexpected opening for July 1, 1981 in fully approved three year program in large community teaching hospital. Write or call, Dept. of Health Educ., St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

LOCUM TENENS — Pediatrician wanted to cover practice in a beautiful resort area, beginning June 12 til July 12, 1981 for either two weeks or the entire period. Compensation negotiable. Please contact: Nora F. Chang, MD, FAAP, 828 Oak St., Cadillac, MI 49601. Phone: 616/775-4696.

PATHOLOGY RESIDENCY — Grad Year I — Unexpected opening for July 1, 1981 in fully approved four year program in large community teaching hospital in Detroit. Write or call, Dept. of Health Education, Saint John Hospital, 22101 Moross Rd., Detroit, MI 48236. (313) 343-3875.

Ear, Nose and Throat practice available. Established for the last 40 years. Located in Southfield, Michigan, in medical building adjacent to hospital in prime medical/commercial area. Excellent opportunity for new practitioner, or for established surgeon to expand own practice. For information call (313) 569-6569.

PEDIATRIC RESIDENCY — Grad Year II — Unexpected opening for July 1, 1981, in fully approved three year program in large community teaching hospital in Detroit. Write or call Dept. of Health Education, St. John Hospital, 22101 Moross Rd., Detroit, MI 48236. (313) 343-3875.

OB-GYN: Board eligible or certified to join busy practice in a beautiful resort area close to Detroit. Excellent office located one mile from hospital. No investment required. Equal work. Salary open. Partnership available after first of year. M. I. Sabbagh, MD, P.O. Box 163, St. Clair, 48079. 313/329-7000.

PART-TIME PHYSICIAN needed to do routine physicals to assess donor suitability for plasmapheresis. Good position for older physician looking to slow down. Malpractice coverage provided. Contact Thomas Anderson at American Plasma Management, Kalamazoo, MI. Phone 616/381-0086.

Ob/Gyn practice open in Mt. Clemens area. Present incumbent retiring when suitable, qualified applicant applies to take over office. Write O.W. Oughtred, MD, F.A.C.O.G., 35992 South Gratiot, Mt. Clemens, 48043.

LOCUM TENENS WORK WANTED. The more you know about choices, the easier it is to choose. That's why CompHealth, the oldest, largest locum tenens organization in the United States, can help make choices easier for you. Any specialty can be covered including: FP, IM, Rad., Anes., and Ob/Gyn. With a large selection of reliable qualified physicians to choose from, CompHealth provides physicians, hospitals, clinics and communities with dependable locum tenens coverage, allowing you to keep your practice covered without inconvenience or concern. Turn a difficult decision into an easy choice. Contact CompHealth, 175 West 200 South, Suite 2003, Salt Lake City, UT 84101. 801/532-1200.

Primary Care Physicians for independent family practice, internal medicine, and pediatrics. North Central Wisconsin. Excellent clinical facilities and assured support of independent practitioners. P.O. Box 801, Neenah, Wisconsin, 54956.

Positions With The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All inquiries treated confidenitally. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Positions wanted

Urologic Surgeon seeks practice opportunity in West Michigan, solo or group. University trained, board certified, 5 yrs. solo practice. Previously board certified anesthesiologist. American, University of Michigan graduate 1959, christian, married 24 yrs., 5 children. Richard M. Delnay, MD, 1646 Sam Houston Dr., Harlingen, TX 78550.

1980 GRADUATE DUKE UNIVERSITY Physician's Associate Program seeks challenging position. Main interests are family practice, internal medicine, pediatrics, and emergency medicine. Prefer rural community. Will relocate for right position. Contact Susan McCoy, P.A.-C., 700 Ninth St., Three Rivers, Michigan 49093. 616/273-8931.

Miscellaneous

UTICA, MICHIGAN — 1,500 sq. ft. modern medical office, air conditioned with small-town ambience. Ready soon as redecorated. Phone Wilke Realtors for lease details. 1-313-731-7600.

RE: USED X-RAY AND MEDICAL EQUIPMENT. If you had dealings with A. Zieman Co. and have comments, please notify us at Box 17, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

FOR SALE — CHICAGO Gold Coast John Hancock condo. 3 blocks Northwestern Hospital and University; also easy access other universities and hospitals. Busses one-half block away; walk to Loop and financial district; excellent shopping, restaurants, etc. Many high caliber professional and corporate executive unit owners who demand the finest in condo living. Excellent in-town residence. Amenities included in assessment: large all year indoor pool, saunas, exercise rooms, eliminates outside health club membership. Laundry rooms, bicycle rooms, own private storage locker on apartment floor. Access within bldg. to garage, office complex, shops and bank. Main 44th floor Sky Lobby has commissary, private restaurant for unit owners and guests; receiving room, valet shop and party room. Beautiful large one bedroom on 76th floor unobstructed view Lake Michigan; eat-in kitchen, 2 huge walk-in closets, linen closet; levelor blinds and sheer draw curtains, unusual parquet floors. Monthly assessment $174. Annual taxes below $800 for 1980. Price $150,000. Private owner relocating. Call after 5 P.M. 312/664-4665.

REAL ESTATE DEVELOPMENT AND ZONING. Prior to purchasing investment property, you should be aware of how much floor space the site can support, zoning restrictions and the market feasibility of the intended use. Villican-Leman & Associates, Inc., Community Planning Consultants, are experts in planning and zoning analysis, market feasibility studies, mortgage submission packages, site planning, landscape design, and more. Call or write for prospectus or further information: 29621 Northwestern Highway, Southfield, Michigan 48034. 313/356-8181.

FOR LEASE — Office of former busy general practice now occupied by mental health group. 1680 sq. ft., four exam rooms, private office, x-ray room, in Romulus, Mich. Available in February, 1981. Option to buy, with dental clinic already leased in same building. Call 313/761-3465 days or evenings.

LAKEFRONT HOME. Southern Jackson County. 175 feet of water frontage. Year around home with four large bedrooms, two full all-ceramic tile baths with vanities. Approximately 2300 sq. ft. of living area. Expressway driving time to Wayne State Medical Center in Detroit — 1 hr. 30 min.; to University of Michigan Medical Center in Ann Arbor — 30 minutes. Write Owner, 23202 S. Brookside Dr., Dearborn Heights, MI 48125.

TAX SHELTER — Let us show you how your office equipment, furnishings, or library can be converted to a conservative tax shelter which will double your true investment in six years. We are a physician owned company with experience in meeting the financial needs of physicians and other professionals. Call us first for signature loans. Fast, confidential service. Tri-City Capital, Inc., 1420 Center Avenue, Bay City, Michigan 48706. 517/894-2051.

St. Clair Michigan — Modern medical office, near hospital, 1200 sq. ft., available January 1981. Good growth location and pleasant living. Ample parking. Reasonable rent. Call M. I. Sabbagh, MD, 1-313-329-7000.

Howell, Michigan — 8,000 sq. ft., medical-dental, available January, 1981, in attractively designed professional building. Complex conveniently located within walking distance of hospital which serves fastest growing county in state. For information, call evenings, 517/546-8895.

OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury, two & three bedroom units. Near Boyne ski hills. $92,000-$96,500. Furnished unit rentals available for vacation year round. A.K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

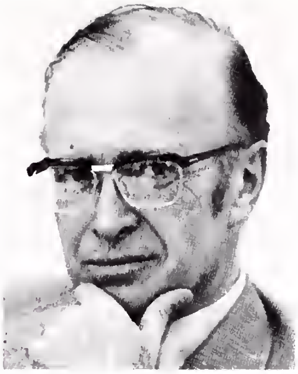
St. Thomas, U.S.V.I. Ocean front condominium villa. Sleeps 4-6. Three pools, free tennis, duty free shopping. List of local medical meetings available. Reduced air fares. 313/543-2970 or 542-7600.

Hilton Head Island, SC. Ocean Villa, Captain's Cove in Palmetto Dunes Resort. Luxurious new villa, 150 yds. from beach. Lagoon backyard, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, pool, fishing, canoeing, biking, etc. Weekly, monthly. Call or write, 313/695-0356, 6236 Kings Crown Rd., Grand Blanc, MI 48439.

2-3
Orthopedic
Surgeons

Board certified or board eligible to establish own practice. Busy orthopedic oriented hospital. Over 50 percent surgery at our hospital is orthopedic. Reconstructive, trauma, hand, etc., — all available. Excellent opportunity for those just finishing training. Hospital and other orthopedists will assist in establishing practice.

Contact: Chief Dept. of Orthopedics, Ingham Medical Center, 401 W. Greenlawn, Lansing, MI, 48909.



Government, stay off our backs; we'll take it from here

By John R. Ylvisaker, MD, MSMS President

For years we as citizens and health care providers have been outspoken in our criticism of government: "Government, get off our backs — leave us alone — cut out deficit spending — quit taxing us to death — go back to what you're supposed to do!"

In November '80, a strong voter majority told the government: "We meant what we said — get off our backs!" And President Reagan emerged with what most have viewed as a mandate to reduce inflation, taxes, and the over-growth of a government "out of control."

On Feb. 18 and March 10, Reagan's team came through with what we have been urging: a program to reduce federal spending, to work toward a balanced budget, to eliminate unneeded or wasteful government services, to return more control to state government, and to shrink the regulatory monster.

Result? Initial applause — then shrieks of pain and protest from every "ox" gored, or only grazed, by Stockman's knife.

I'm no expert on the many areas of the budget that have been evenly, though slightly, whittled. But I know that the recommended budget reduction of approximately $50 billion is only about one-half the anticipated budget deficit, and about seven percent of the total budget (less than six percent if off-budget commitments are considered). Many think the cuts are too small — we all know there's more "fat."

But the direct concern relates to the reductions recommended for the health care industry: $5.2 billion over-all by the last count. And the protests are swelling!

How can we possibly complain? Or should I say, how dare anyone complain? The June to June '80-'81 national health care expenditures totaled between $227 and $240 billion. Federal expenditures at 40+ percent were about $100 billion. The cut? Less than 2.3 percent of total, or 5 percent of federal spending, and right on target:

Health planning — costly, highly politicized, and judged by repeated studies to be ineffective, time-consuming, and often disruptive.

PSROs — over-all a failure at cost-effectiveness with a very spotty record of achievement of what we are, or should be, doing for ourselves: peer review.

HMOs — it's about time to end discriminatory subsidies.

Health Professions Education and National Health Service Corps — The subsidy programs filled a definite need in their time, completed their task, and now are subject to substantial cutbacks on a priority basis. Support for minorities, specific manpower shortages, and needy students will *not* be eliminated, but will actually get more attention.

PHS hospitals and merchant seamen — PHS hospitals have only 60 percent occupancy and only one-third of users are seamen. Haven't we already identified that there are too many beds and that private hospitals can do it better and cheaper?

Categorical grants — These will be replaced by "block grants" with local responsibility for spending decisions. Local control should result in better decisions, greater efficiency and compensatory savings.

Medicaid — a "mixed blessing" program representing the best of American idealism, of great benefit to many, but parts of which are almost a national disgrace. The cuts are insignificant initially ($100 million) and they propose only limiting growth to five percent per year. *Most important*, the recommended changes free the states to determine eligibility, benefits, and levels of payment. If our own state is any example, this would be the greatest opportunity to "clean up our act." In Michigan, 10 percent of our budget ($1.1 billion) goes to match an equal amount of federal dollars to a total of $2.3 billion! To do what?

— To provide little more actual health care than a fraction of those dollars bought pre-Medicaid.

— To do substantially less than what is promised.

— To undermine the self-sufficiency and pride of many, and to consign many of those truly in need to the realm of bureaucratic paper and patronage, Medicaid abuses, and gradual loss of access to caring physicians.

— To alienate many physicians from a traditional professional responsibility to care for the sick regardless of ability to pay.

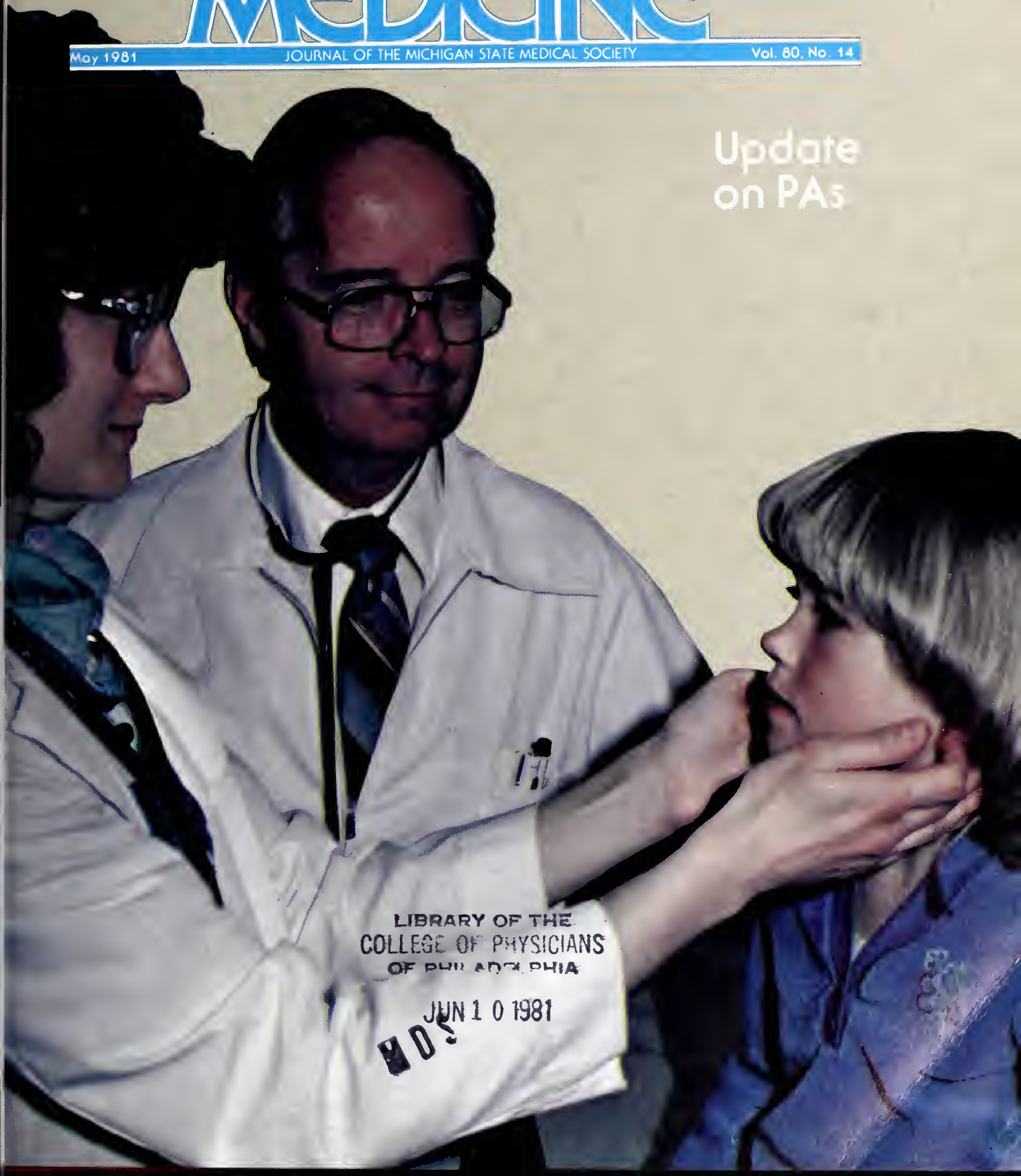
Truly, if we are protesting, we must have grown soft or have lost perspective. We can do better. We as citizens/providers can and should assume the responsibility of positive leadership.

Government, thank you for what you've taught us. Stay off our backs. We'll take it from here.

MICHIGAN MEDICINE

May 1981 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 80, No. 14

Update on PAs



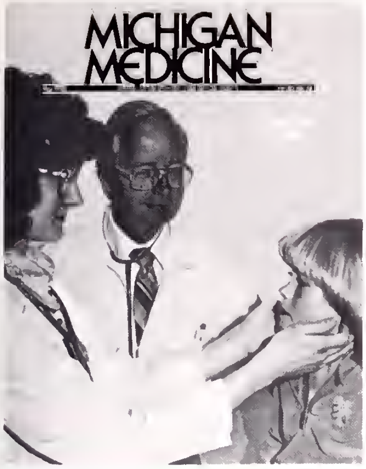
LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JUN 1 0 1981

Who to call at MSMS headquarters

Advertising (in *Michigan Medicine*)	Bonnie Groff
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Arrangements	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Marce Ireland
Category I Calendar (for *Michigan Medicine*)	Bonnie Groff
MSMS-Sponsored Conferences	Sherry Fent
Dues Payments	Jerry Trahan
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	John Richards
Health Planning	Dennis Paradis
Impaired Physicians	Marcelyn Ireland
Jail Health Project	David Schut
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
Medical Assistants	Caroline Rich
Medical Auxiliary	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Bonnie Groff
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Vi Heins
Michigan Doctors Political Action Committee	Kevin Kelly
Michigan Medicine (MSMS Journal)	Judy Marr
Michigan Psychiatric Society	Helen Schulte
Michigan Society of Anesthesiologists	Caroline Rich
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Arrangements	Marce Ireland
MSMS News Relations	Mert Scholten
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
Physician Hospital Relations	Bill Madigan
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	Bill Madigan
PSRO	Sherry Wellman
Socio-Economic Surveys	John Richards
Specialty Societies	
Information	Nancy Wimmer
Council of Specialty Societies	Bill Madigan
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society
120 West Saginaw (Box 950)
East Lansing, MI 48823

MSMS PHONE: 517/337-1351



Lydia Beckwith, PA-C, left, assists Donald R. McCorvie, MD, in his Williamston practice. In our cover photo, Ms. Beckwith examines Erin Phillips, 7, of Williamston. They agreed to appear on our cover this month to illustrate our special report on the current status of physician's assistants in Michigan. **(Photo by Mert Scholten, MSMS staff.)**

MICHIGAN MEDICINE

May 1981, Volume 80, Number 14

Special report

208 There are an estimated 300 physician's assistants employed by doctors in Michigan. But their legal and legislative status is in limbo, with no formal rules and regulations written. Probably the best guidance on the physician-PA relationship is provided by the AMA. A full discussion of the issues, the statistics and the AMA's sage counsel appears in this month's special report; Dwight Angell

Features

214 Physicians and the health care team: Hiring the nurse clinician; Oliver D. Grin, MD, and Dorothy L. Bouwman, RN, MSN

216 Certified medical assistant may be the personnel needed in ambulatory care; Carol Campsmith, RN, CAM-AC, MA

218 Component society officers listing

227 An investment strategy for the 80's; David M. Buegeleisen

234 Cost containment: Fiscal responsibility is part of good management; William T. Rice, MD

236 How MSMS dues compare with other state societies'

260 AMPAC is the premier PAC; Thomas R. Berglund, MD

262 Congress to reappraise all of medicine in next two years; Theodore N. Cooper, MD

Departments

206 In my opinion; James H. Tisdel, MD

207 Letters

224 News

238 New members

244 MSMS Q/A

246 Medico-legal; Elmer White

253 Medical newsfronts

257 Meetings

258 Category I courses

264 Deaths

266 Classified ads

267 Ad index

268 President's page; John R. Ylvisaker, MD

IN MY OPINION

Thoughts on seven years of MSMS publications history

By James H. Tisdel, MD, Port Huron

Shortly after I became chairman of the Publications Committee seven years ago, the objectives and format of *Michigan Medicine* were changed. Now my chairmanship of the committee is coming to a close. It is time for me to ponder what and why we did, how we did, and what will be done in the future.

How effective have we been? Have we helped our members have a clear insight into the problems our profession encounters in the social, economic and governmental arenas? Have we, and are we, communicating effectively?

A review of recent topics presented or to be presented, shows the variety and timeliness of our journal. These articles include opinions and information on the following subjects: physicians and hospitals, ambulatory surgery, physician extenders, radial keratotomy, hospice update, the economy's effect on medical practice in Michigan, the current status of the malpractice problem, and, in future editions, cancer research and treatments, MD cost-cutting ideas, the role of medicine in public policy, and the MSMS vs. FTC story.

This list is not complete, but demonstrates the wide range of subjects we have presented, and will present. We believe it is important to make this information available to all the doctors of Michigan in an effective and useful journal. Our changes have been guided by multiple surveys of our readers during the past six years. We have polled delegates at our annual meetings, we have sought out your opinions and we want to know what you think.

What has to be done? We want to reach more doctors in Michigan. We must increase membership. We want to become a stronger and more effective voice, not only for our members, but also for those we invite to join us. We must continue to be aggressive policy-makers in our profession and in our communities. We must have our publication in a position to reach the new horizons. The problems are many, and the solutions difficult, not only for medicine, but for all of society. I believe we have improved our ability to communicate through the new *Michigan Medicine* and *Medigram*.

So, now comes the end of my service on the Publications Committee. It has been a very rewarding seven years, full of happy memories. It has been a great experience for me. I have learned much, and gained much wisdom from my association with my fellow counselors on this committee, past and present. I have had the full support of Warren Tryloff and staff at headquarters. I had the opportunity of working with a great communicator, Herb Auer. Finally, I have had the great privilege of working with a true professional, Judy Marr, dedicated and efficient. I feel the future of our publications is sound. They remain in the stewardship of very wise and dedicated people, and that's the bottom line.

Doctor Tisdel is completing nine years' tenure on The MSMS Council. He has served seven years as chairman of the MSMS Publications Committee, which is appointed from The Council.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
James H. Tisdel, MD, Port Huron, Chairman
Busharat Ahmad, MD, Marquette
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $20.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. ©1981 Michigan State Medical Society.

LETTERS

Doctors and nurses

I have just read Doctor Harvey Andre's IN MY OPINION letter in the November 1980 issue of *Michigan Medicine* and must personally respond to him.

First let me identify myself and my role and association with both nursing and medicine. I am an RN with a BS degree in nursing and a masters degree in education (major — nursing education). I am currently teaching in a baccalaureate program of nursing education. I am married to a surgeon who has had the accepted four year undergraduate, four year medical school, one year internship and four year residency program in general surgery. I have one daughter who is in her second year of medical school, and one daughter who has recently completed a baccalaureate degree in nursing. As the wife of a physician, I have actively participated in our county medical auxiliary and in its efforts to assist in presenting medicine and our free enterprise system of medical care in a positive and constructive way to our community.

But I feel there is nothing more destructive to the image of the medical profession and to the lay person's understanding of the availability and quality of medical care than medicine's patronizing ignorance of the contributions of other members of the health care team — whether those other members be physical therapists, respiratory therapists, clinical pastoral counselors, medical social workers, or nurses!

To presume that medicine and

continued on page 222

Nursing education

In February, 1981 I read with great interest the November *Michigan Medicine* article titled "Communication Must Be Open Today Between Physician and Nurse." Portions of this article prompted me to respond that many Michigan nurses are expressing serious concerns relating to professional problems within nursing at this time.

The public (including physicians, nurses and consumers) should be aware of some statistics published by the Michigan Cooperative Health Information System through the Michigan Department of Public Health. In 1979, the estimated number of *active* registered nurses in Michigan (RNs) was 45,232. Percent distribution based on survey for initial nursing education revealed that of the 45,232 RNs, 21.2 percent had associate degrees, 64 percent had diplomas and 14.8 percent had baccalaureate degrees. Therefore, in 1979, 85.2 percent of active Michigan RNs had less than a baccalaureate degree.

These statistics are important for the public's awareness, when one considers the Michigan Nurses Association's (MNA) proposal to establish two levels within the nursing profession. The media should exercise caution in using terms "technical" vs "professional" nurse since these terms originated through MNA alone, via the national association. Theoretically, it is possible that if all Michigan RNs were polled, the majority of nurses might *not* be supportive to MNA's proposal for the BSN to be the basic entry into *professional* nursing. It was estimated in 1979 that the number of Michigan RNs (inactive as well as active) approached 60,000. If the membership of MNA is slightly over 8,000, MNA's proposal is not representative of all Michigan RNs. Facility employment and professional discrimination have already been established in some areas of Michigan due to MNA's proposal.

The public should be cognizant of other viable nursing organizations within Michigan that may have varying philosophies/objectives apart from MNA. These nursing groups should be equally recognized and *represented* on physician/nurse/health care team task force groups.

There are multiple mechanisms to enhance the progress and *quality* of the nursing profession (i.e. facility inservices, continuing educational credits through symposiums, peer review and nursing research) aside from mandating degrees. There is a *natural evolution* within nursing to higher academia without legislatively mandating degrees that perpetrates the discrimination in Michigan today. In time, when the statistics reverse themselves and BSNs compose the majority of RNs in Michigan, perhaps it will be more appropriate to mandate degrees without serious repercussions to other RNs, urging them out of Michigan's work force.

We must be perceptive of each *individual* nurse's qualities and competencies without challenge of how many initials follow the RN. Each Michigan nurse "individually" and "uniquely" contributes within today's health care delivery system.

Nurses need to settle their own professional differences so that they might re-direct their energy to their patients and other health care members. The nursing profession cannot afford this fragmentation, turmoil and internal conflict.

B. Kaye Olson, R.N.
Please direct your comments to:
1306 Sandhill Drive
DeWitt, MI 48820

More letters on page 222.

"How can I kick a bad habit, man?, fiber, bran, niacin, biotin, thiamine . . . "

SPECIAL REPORT

Update on physician's assistants

By Dwight Angell, special to Michigan Medicine

Despite legal and legislative limits, Michigan physicians are hiring PAs

For reasons not entirely clear, a physician assistant in Michigan is treated like a bastard child: little acceptance, little recognition, lack of solidified identity.

The problem rests less with the public and more with the misunderstanding and ignorance displayed by other health care professionals, physicians included, according to sources interviewed for *Michigan Medicine*. And the legislative quibbling in Lansing also has contributed to the confusion as to the role and scope of a physician assistant.

It is the task of this article to shed some light on the nature of physician assistants, based on interviews with PAs and physicians who employ PAs.

Perhaps the best place to start is the state legislature itself. In a joint House and Senate resolution in 1976 commending the PA training program at Detroit's Mercy College, the legislature accurately reflected the philosophy of PAs:

"A physician assistant is a skilled person qualified by academic and practical clinical training to provide medical services under the supervision and direction of a physician. In such a capacity, the physician assistant is able to perform many of the tasks previously done by a doctor, thus allowing the physician more time for greater medical services.

"Physician assistants are of extreme importance in increasing the productivity of licensed doctors. Indeed this has been most apparent in the inner city and rural areas where physicians are often overburdened. To this end, physician assistants represent a wise use and conservation of human resources."

The PA movement began in the mid-sixties at Duke University, primarily for two reasons: Vietnam veterans with medical experience were seen as untapped resources for civilian medical services; and secondly, studies consistently pointed to the problems of rural and inner city areas where there was a lack of physicians to adequately serve the population, coupled with the rapid increase in medical services demanded by people.

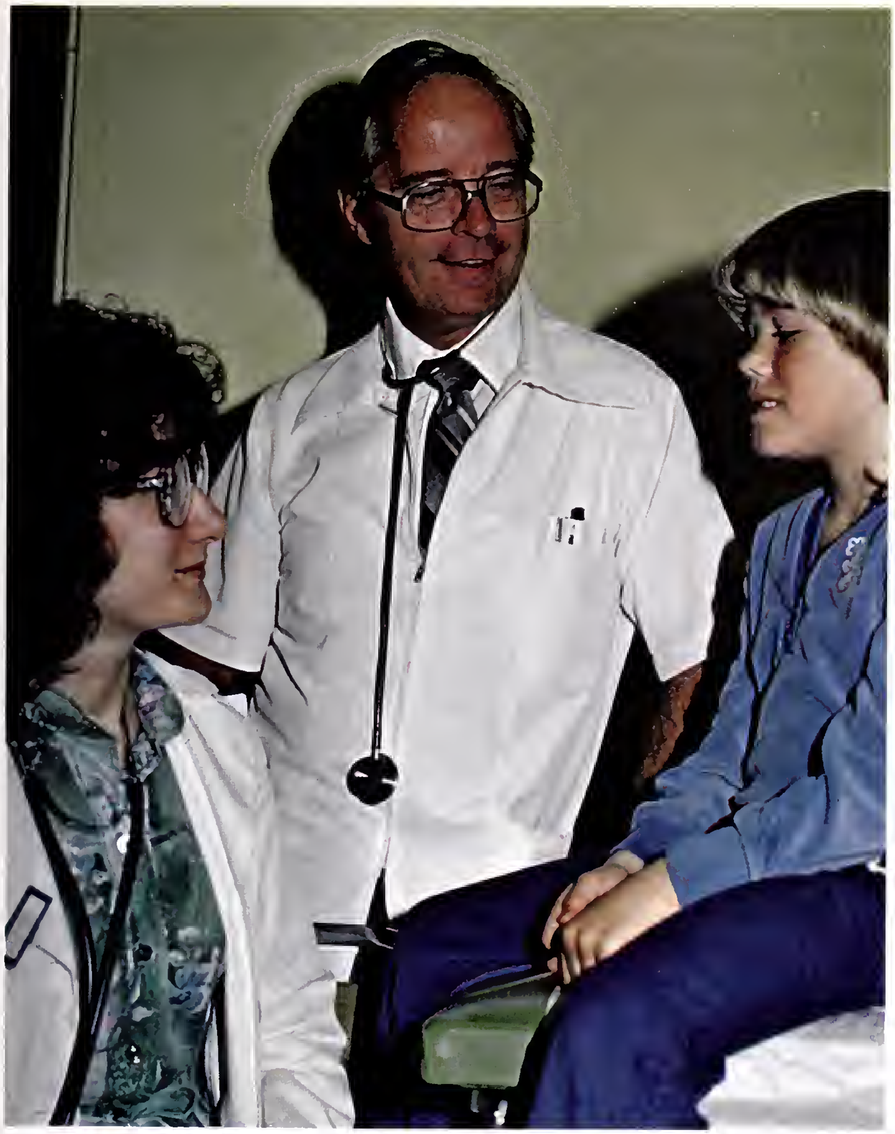
In Michigan, two schools, Mercy College and Western Michigan University, established PA degree programs. MSMS worked closely and at length in the development of Western's program. Both graduated their first classes in 1974. Each school accepts only 25 students per year for the two year program.

To fully understand the problem of acceptance PAs have had to endure since their genesis seven years

Facts and figures on Michigan PAs

Source: Harriet Gales, Mercy College

- The vast majority of graduates are practicing in a primary care setting. One out of four graduates is in a solo practice setting, followed by family practice residency (18 percent); hospitals (12 percent); and health maintenance organizations (11 percent).
- Beginning salaries for PAs has risen dramatically since 1974. In that year, a PA would expect to make $13,350. Last year, the average salary for a PA was $19,580.
- Out of the 152 graduates, only six have gone on to medical schools despite concern that a PA program could be used as a stepping stone to medical school. When the Mercy College program started, there also were fears that it would become a dumping ground for frustrated medical school rejects. That has not happened either, according to Ms. Gales.
- 42 percent of the PAs are located in the inner city and 17 percent practice in rural areas.
- Most applicants to the program are males, about one-fourth veterans, with the bulk in the 22-29 age range. About 40 percent hold baccalaureate degree and the majority have 1-5 years of health-related experience.



Physician's assistant Lydia Beckwith, PA-C, and Donald R. McCorvie, MD, chat with Erin Phillips, 7, of Williamston, at the close of history-taking.

ago, it is important to understand the definition of a PA.

A PA is an assistant to a physician; not an assistant physician. By law, a PA cannot practice independently of a physician. A PA extends the arm of a physician; he or she does not replace it. A PA is trained to know what he or she can and CANNOT do. The PA's role, function, scope, entire livelihood are dependent upon the physician.

Archie Bedell, MD, PhD, family physician at the Family Health Center (satellite of Bon Secours Hospital) in St. Clair Shores, supervises two PAs, including his wife, Linda.

Doctor Bedell has been a proponent of the PA movement since Day One. And he is acutely aware of the resistance among other physicians and other health care providers to the acceptance of PAs into the mainstream of health care. It is his contention that this resistance, and sometimes hostility, is based on misunderstanding.

"I think the basic problem is that most physicians are unaware that the PA must adhere strictly to the rules and regulations established by the physician.

My two PAs are able to work via an established protocol for what they are allowed to do. The PA comes under the specific direction and supervision of the physician — in contrast for instance, to nurse health practitioners who really are licensed to practice independently of physician supervision.

"PAs often are perceived by physicians as being another group of practitioners in competition. And that is exactly wrong! Because PAs are not in competition with the physician as the independent nurse health clinician might be."

As the legislative resolution stated, PAs can be utilized as tools in areas underserved by physicians. One such area is Sterling, Michigan, about 40 miles north of Bay City. There, Gordon Page, MD, a member of the National Health Service Corps, is a general practitioner in the Sterling Area Health Project. He employs both a PA and a nurse practitioner.

For his type of practice, a PA is a necessity. For it is not only the office visits he must attend to, but also the local emergency room, to which he drives at least once a day. Meanwhile, his office has 10 to 15 patients waiting. Because of his general/family practice, many of the problems — sore throats, hypertension checks, colds — "things that really don't need the training of four years of medical school, internship and residency," are handled by his PA.

"The way I view the PA in this type of practice, he is an extension of the physician," he says. "A lot of routine, mundane daily types of chores that need to be done, he can do just as adequately.

"PAs allow the physician to provide better health care in an underserved area. The physician-PA team can see more people. But it also gives the physician the time to spend with sicker patients or to deal with more complex problems, so that the patients are actually being better served."

Serving more patients is certainly one advantage in using a PA (a fear expressed privately by individuals is that PAs could be used by physicians for only one reason — to increase a physician's income). But another reason for selecting a PA is the type of training a PA receives. Says Doctor Page: "The PA is geared towards treatment."

Harriet Gales, director of the program at Mercy, said that the trained PA has a strong background in data-gathering, diagnosis, patient education and management.

"A PA can perform about 75-80 percent of what a family physician can do."

The other problems that have confused health professionals regarding PAs are the result of a murky

New AMA report provides guidelines on physician's, assistant's relationship

With Michigan physicians hiring physician's assistants in the absence of formal rules and regulations, it is helpful to turn for official guidance on these relationships to AMA policies and actions.

Michigan PAs are licensed by the Board of Medicine, which also is in charge of developing the long-awaited rules and regulations for PAs' activities. MSMS, the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS), and the Michigan Academy of Physicians Assistants (MAPA), all have provided their recommendations, but the board has not established what the rules and regulations should be to this date. Thus there is no joint action at present by Michigan MDs, DOs and PAs on the subject.

The best official stand of organized medicine available at present is that of the AMA. Its Joint Report of the Board of Trustees, Council on Medical Education and Council on Medical Service, "Evaluation of AMA Policy on Physician's Assistants," was adopted by the December, 1980 Interim Session of the AMA House of Delegates.

The joint report evaluates the AMA's policy on PAs, opposing increased public funding for physician's assistants training programs, urging that PAs be authorized to provide care only under the supervision of a physician, and opposing giving PAs the authority to prescribe independently.

Recommendations of the report, as adopted by the December 1980 interim AMA House, are:

Recommendation 1: Manpower supply

Legislation to increase public funding for programs to train physician's assistants should be opposed, and there should be careful re-evaluation of the need for public funding at the time that present legislative authorities expire.

Recommendation 2: PA functions

A physician's assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the PA's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician's

---

PA UPDATE/*continued*

legislative history as confusing as it is long.

PAs are fully recognized and licensed under the state's new Public Health Code. Except in one state, PAs are recognized as a category of health care professionals. But states vary, quite dramatically in fact, as to the exact role and scope of activities for a PA's practice.

But there have been two areas of legal contention, one of which was resolved last spring and one that is still continuing.

According to Karen Kotch, a PA at Henry Ford Hospital's satellite in West Bloomfield and chairperson for the seven-member Task Force on Physician Assistants, the issue of licensure and educational requirements for PAs has been finalized.

When the original law was enacted by the state legislature, a grandfather clause essentially allowed almost anyone who called himself a PA to function as one. Until last year, there were an estimated 300 persons who were considered on this "interim" basis and another 150 or so who were fully licensed by the state.

The Task Force's function was to promulgate specific rules for licensure.

That accomplished, there are now only two possible statuses for the estimated 300-350 PAs now practicing in Michigan, says Ms. Kotch: permanent or temporary.

A permanent PA has successfully completed an accredited program and passed the exams of the National Commission on Certification of Physician Assistants. A temporary status applies to a person who has passed a program but is waiting to take the test. These new criteria have effectively eliminated persons who lacked proper qualifications.

Confusion continues in the second area. It has to do with rules and regulations needing promulgation by both the Board of Medicine and the Board of Osteopathic Physicians and Surgeons. The boards are assigned to specify exactly what a PA can and cannot do. But the boards have failed to reach an agreement over the years.

According to Henry Kallet, MD, member of the Board of Medicine and a pathologist at Chelsea Medical Laboratories, the areas of continued disagreement are: degree of freedom in the performance of surgical procedures; prescription of drugs and degree of supervision by a physician and specifically what constitutes effective supervision.

Which all seems to add up to a legislative and legal limbo for physicians employing or considering hiring a PA.

But all individuals interviewed feel there is no need for apprehension on the part of a physician hiring a PA.

Says Kallet: "I would not discourage a physician from hiring a PA. Until the rules for defining the scope of practice, one must use the test of reasonable, customary usage."

Says Doctor Bedell: "I don't feel any apprehension. This is a matter of recognizing that the buck stops with the physician in charge. The physician must make the ultimate decision as to how far he wishes his PA to go in relationship to certain practices in medicine and/or surgery."

Bedell believes that one of the causes of the rules confusion is that persons involved haven't recognized the rules must not be restrictive.

assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician's assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician's assistants that the physician or group of physicians plans to employ and supervise.

A physician's assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board.

State medical licensing boards, in their review of applications for utilization of a physician's assistant, should take special care to insure that the PA functions proposed not be of a type which (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician's assistant, or (c) would authorize the unlicensed practice of medicine.

Recommendation 3: Physician supervision

The physician's assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician's assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician's assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times.

The physician's assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home.

The state medical licensing board should determine on an individual basis the number of physician's assistants that a particular physician may supervise or a group of physicians may employ.

Recommendation 4: Hospital employment

While it is preferable and desirable that the physician's assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician's assistant is employed by a hospital, the physician's assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed PAs functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician's assistant in accordance with a specific utilization plan and who should be directly responsible as the attending physician for the patient care services delegated to his physician's assistant.

Recommendation 5: Prescribing by PAs

The AMA opposes legislation or proposed regulations authorizing physician's assistants to make independent medical judgments as to the drug of choice for an individual patient.

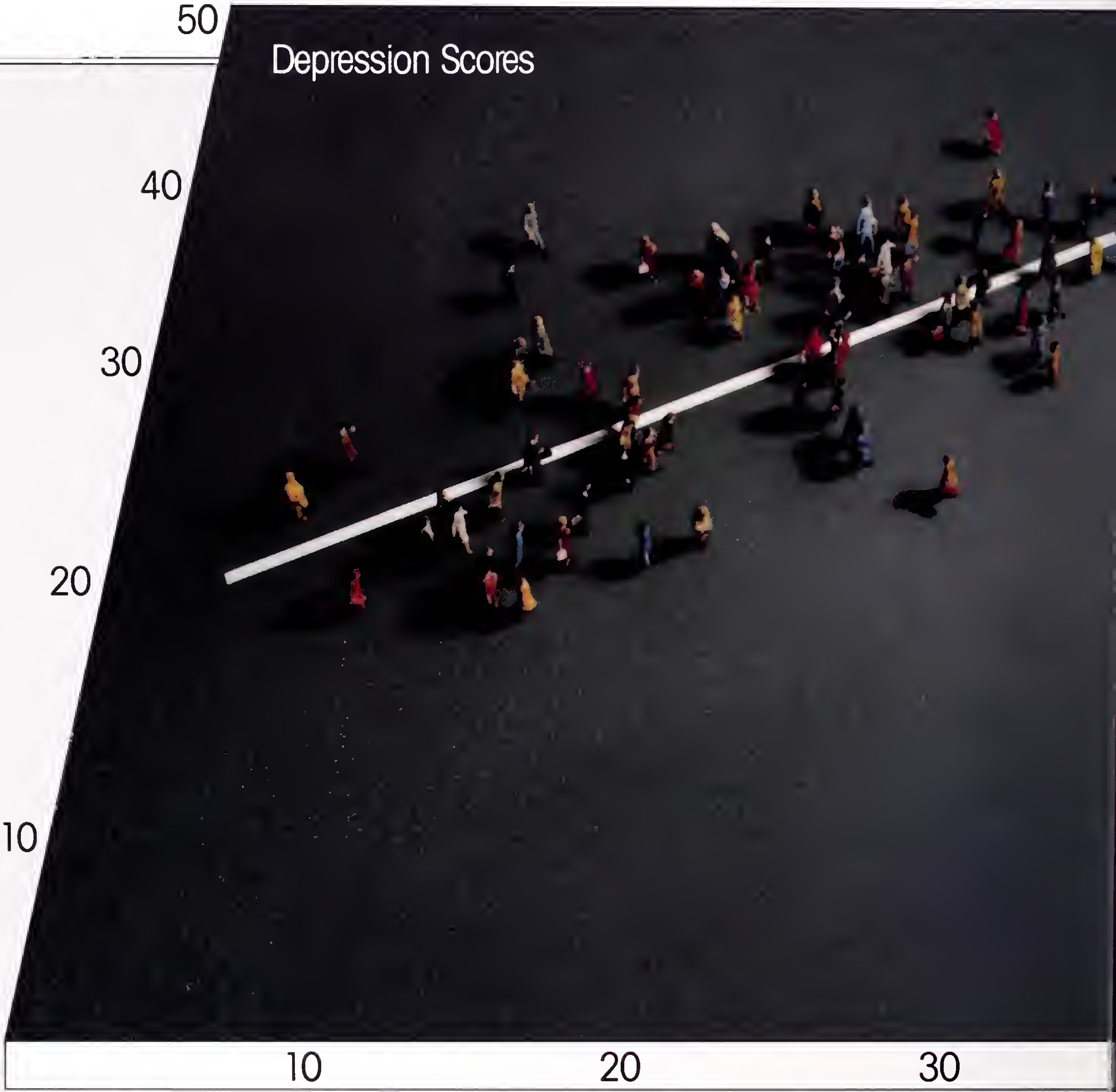
AMA opposes increased funds for training physician's assistants

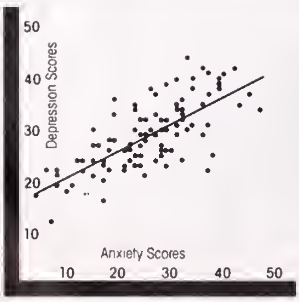
The impact of recent studies predicting surpluses of physicians caused the AMA delegates to take their stand December, 1980 against public funding to train more physician's assistants.

Here is how the AMA assessed the impact of these projections on the future supply of physician's assistants and the professionals they serve:

The joint report reemphasizes the need for continued efforts to improve methods for monitoring the adequacy of the health manpower supply, both geographically and by specialty area, so as to insure the appropriate and efficient expenditure of public funds, and the provision to individuals interested in the health field of information enabling an informed choice of careers. The development and nurturing of the physician's assistant came at a time when there was a perceived shortage of physicians and/or physician's services in the late 1960s, points out the report. The projections for greatly increased numbers of physicians in the near future raise serious questions as to the wisdom of providing additional special subsidies for educational programs for physician's assistants, it concludes.

FOR THE 7 OF 10 NONPSYCHOTI





Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3] Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE®

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]

Most depressed patients are also anxious…

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Cloghorn J: The anxiety-depression syndrome. *Psychosomatics 11*:438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61*:217-225, 1979.

In moderate depression and anxiety

Limbitrol® CIV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses Myocardial infarction and stroke reported with use of this class of drugs) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e g operating machinery, driving)

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients Periodic liver function tests and blood counts are recommended during prolonged treatment Amitriptyline component may block action of guanethidine or similar antihypertensives Concomitant use with other psychotropic drugs has not been evaluated sedative effects may be additive Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment See Warnings for precautions about pregnancy Limbitrol should not be taken during the nursing period Not recommended in children under 12

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects

Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs

Cardiovascular Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido

Neurologic Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns

Anticholinergic Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels

Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive I V administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained Larger portion of daily dose may be taken at bedtime Single *h s* dose may suffice for some patients Lower dosages are recommended for the elderly Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12 5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50

ROCHE
ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

Physicians and the

Articles on this and following pages discuss various aspects of the physician's professional relationship with medical assistants and nurses.

Hiring the nurse clinician

By Oliver D. Grin, MD
Dorothy L. Bouwman, RN, MSN
Grand Rapids

Doctor Grin is a neurosurgeon, affiliated with Blodgett Hospital, and is associate clinical professor, Michigan State University College of Human Medicine. Ms. Bouwman is a clinical nurse specialist and teaches continuing education courses for nurses through the University of Michigan College of Nursing and Grand Valley State College of Nursing.

SPECIFY
ZYLOPRIM®
(allopurinol)
THE ORIGINAL ALLOPURINOL

ZYLOPRIM
U4A
Two convenient dosage forms: 100 mg (white) and 300 mg (peach) Scored Tablets

ZYLOPRIM
C9B
Tablets imprinted with brand name to assist in tablet identification.

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

health care team

The care of the neurosurgical patient has become a very complex situation requiring a variety of medical and nursing skills. These patients and their families deserve the highest level of diagnostic and surgical skills, comprehensive nursing care, detailed patient education, and strong emotional support. The most effective approach is for the neurosurgeon and the neurosurgical nurse clinical specialist to work as a clinical team.

I would like to describe the arrangement and the good experiences of my office which have resulted since I hired a nurse clinical specialist in July, 1979.

Patient's progress

Our team's approach can best be demonstrated by following a neurosurgical patient through the evaluation and management.

The initial office visit is carried out in a two-part process. The nurse clinical specialist first interviews the patient, taking a complete medical history followed by a neurological assessment. The information is then presented to the neurosurgeon who reviews with the patient as much of the history as he deems necessary, and repeats the examination.

The nurse clinical specialist and the neurosurgeon then jointly review the patient's examination. The physician makes the tentative diagnosis and discusses its ramifications with the patient. Various studies are recommended and discussed with the patient. Appropriate scheduling is arranged by the clinical nurse specialist, and if there are further questions, these are answered at this time.

With a typical neurosurgical patient, the next phase of care involves hospitalization. On the evening of admission, the patient is visited by the clinical nurse specialist and the neurosurgeon. An updated medical history and examination are made and recorded on the chart. The proposed studies and/or surgery are discussed by the clinical nurse specialist to include the use of visual material. The surgeon then has the opportunity to answer any final questions regarding the proposed procedures. The next morning, the nurse specialist again meets with the patient to answer any final questions before the proposed procedures.

Daily rounds

Daily rounds are conducted both by the neurosurgeon and the clinical nurse specialist. The neurosurgical patients are evaluated from both the nursing and medical perspective. The visits are recorded in the progress notes by either the clinical nurse specialist or the neurosurgeon. If the former makes the progress notes, the physician countersigns them. On heavily scheduled operating days, the clinical nurse specialist is available within the hospital to consult with the patients and family to provide the necessary information. Similarly, laboratory tests, x-rays, discussions with consultants and various treatments are arranged by the clinical nurse specialist with the guidance of the neurosurgeon.

The discharge process is a combined effort by the neurosurgeon and the clinical nurse specialist. The nurse has begun preparation for discharge several days prior to the event. This includes written post discharge therapy. On the day of discharge, the postoperative program is again reviewed by the nurse, the surgeon making one final review with the patient, answering any lingering questions. Office follow-up and follow-up with other physicians is specifically arranged at that time.

The initial part of the office follow-up visit is made by the clinical nurse specialist to include follow-up history and examination. This is confirmed by the neurosurgeon with recommendations made to the patient. Further treatment, if needed, is arranged by the nurse.

This clinical team approach gives the patient a more comprehensive care program, allows the neurosurgeon time to focus upon those aspects of care requiring his surgical skills, and utilizes the skills of nursing in direct neurosurgical care.

Care enhanced

The above team approach enhances care of the neurosurgical patient. It affords the patient and his family extensive patient education. Documentation of the patient's care is improved and formalized from both a medical and nursing point of view. The nurse clinical specialist acts as an important liaison between the hospital nursing staff and the neurosurgeon. Many heretofore unanswered questions or poorly understood neurosurgical concepts have been clarified for the nursing staff, thus benefiting the patient. Inservice educational programs have been enhanced, and an ongoing program of care of the neurosurgical patient has been introduced to the hospital staff.

Patients have responded favorably to the role of the clinical nurse specialist and, in fact, many of the follow-up calls are directed to the nurse rather than the physician. Additionally, through the nurse clinical specialist, the patients come to a better understanding of the complex role of the neurosurgeon. This leads to a better doctor-patient relationship. Other physicians are pleased with the role of nurse clinical specialist and appreciate the availability of a knowledgeable professional discussing their patients when the surgeon is not immediately available on operative days.

In conclusion, the neurosurgical nurse clinician plays an extremely important role augmenting the care of the neurosurgical patient. This role primarily involves neurosurgical assessment and communication with the patients, their families, hospital nursing staff, and other health professionals including physicians who are sharing in the care of the patient. The role results in a more relaxed and informed patient who is better able to understand and manage his recovery and maintenance of health.

The certified medical assistant helps meet ambulatory care needs

By Carol Campsmith, RN, CMA-AC, MA, Kalamazoo

In the years when medical assisting as a distinguishable allied health profession first began to take hold, physicians commonly trained their assistants themselves. Some office employees had completed formal educational programs in such related fields as nursing, medical technology, business administration, and secretarial; however, no one came to ambulatory health care delivery settings with a complete educational background to function effectively or efficiently.

Radical changes have occurred in the health care delivery system in recent years brought on by the pressing demands of people for a healthier life. These demands are supported by widespread use of health insurance plus Medicaid and Medicare. Concurrently, countless new medical science and technology developments have added to the variety and scope of diagnostic and treatment procedures of the typical medical practice.

The need

A needs analysis of any modern ambulatory health care setting would show that physicians need many functions to support their activity as they provide direct patient care. In the past, the physician had to choose between either the medical technologist or the LPN or RN for clinical support. The alternative was for the physician to hire an accountant or secretary who was untrained and unaccountable in clinical applications.

We recognize that the educational backgrounds of doctors, secretaries, accountants, nurses and laboratory technicians do not include skills necessary to manage the modern health care delivery system in a fashion that enables a patient to be diagnosed and treated by a physician in the same uncomplicated way as in earlier years. The need has been created for an individual who is both educated in and accountable for the effective, efficient management of the ambulatory health care setting.

This need has been addressed by the *American Medical Association*, which, in the interest of ensuring quality in the health care system, has joined with the *American Association of Medical Assistants* to define the role of the professional medical assistant, to develop standards for the educational preparation of board-eligible medical assistants, and to endorse the accountability of the Certified Medical Assistant (CMA) who has successfully passed the National Certification Examinations administered by the National Board of Medical Examiners.

The recommended answer: *Certified Medical Assistants* (CMAs)

Recognizing the need for a *multi-competency ambulatory care practitioner the AMA* joined with the *AAMA* in defining the allied health profession of medical assistant as follows:

> "Medical assistants are *multi-competency practitioners* qualified to provide supportive health care services under the supervision of a physician. They assist with patient care management, execute administrative and clinical procedures, and often perform managerial and supervisory functions. Competence in the field also requires that the Medical Assistant communicate effectively, adhere to ethical and legal standards of medical practice, recognize and respond to emergencies, and demonstrate professional characteristics."

The two organizations cooperate in a program of accreditation to establish and maintain standards of appropriate quality for educational programs to prepare the professional medical assistant, and to provide recognition for those college-level educational programs which meet or exceed the minimal standards outlined in the essentials approved by the *American Medical Association*.

Graduates of accredited medical assisting programs are prepared to work with and under the direction of physicians to provide quality health care services.

Robert E. Kinsinger, Vice President of the W.K. Kellogg Foundation in his address to the *American Medical Association's Allied Health Symposium* in April, 1980; stated that **cost-effectiveness is directly related to the multi-competency capability of the allied health practitioner:**

> "Service issues will be determined by the delivery system, which is simultaneously feeling the strains of cost containment, federally mandated health planning, shifts in public attitudes about health and health care,

---

Ms. Campsmith is medical assistant program director, Kalamazoo Valley Community College.

rogress is continuing on the major conference on womens' health care issues planned by MSMS on Nov. 4. Marguerite . Shearer, MD, Ann Arbor, center, is chairman. The conference will focus on stresses felt by the professional woman.

EDICAL ASSISTANTS/*continued*

> and demographic changes, as well as constant scientific and technological developments. Allied health personnel will adjust their service role as appropriate if their education is based on principles, not routine procedures, if they have an adequate continuing educational system available to them; and if their teachers, mentors, and colleagues help them to understand WHY as well as HOW."

All medical assistant educaional programs in Michigan need he help of the state's physicians ow if we are to provide the pracitioners needed to meet the demands f ambulatory health care today in a ost-effective manner.

As far back as May, and then gain in the fall of 1978, State Repreentative Raymond Hood in a letter o this writer stated the following:

> "The New Public Health Code of Michigan offers a mechanism for looking rationally at the need for licensure and certification through the health occupations council while at the same time providing for the recognition of auxiliary health personpower by allowing the delegation of certain acts, tasks, and functions **to those persons who are competent to carry them out**. Therefore, Medical Assistants are not specifically recognized in the Code at the present time **but are recognized under the delegatory section and are thus permitted to practice under certain specified conditions.**"

He supports, ". . . the utilization of auxiliary medical personnel provided they are competent and can provide quality health care. More and more legislators are becoming concerned about the ever-increasing number of health occupations desiring licensure and are beginning to explore alternative methods for assuring competence and quality." The *AMA/AAMA's National Certification Board Examinations* administered by the *National Board of Medical Examiners* meets the *requirement of accountability* for the Professional Medical Assistant Practitioners.

An appeal

Certified Medical Assistants and college-level medical assistant educational programs in Michigan **need your active support to achieve and maintain the standards adopted by the American Medical Association.**

You can help by:

- Finding out the status of Medical Assistant Education in your community.
- Encouraging your employees to upgrade their competencies and becoming Certified Medical Assistants.
- Identifying the physicians actively involved in the educational process as mandated by the AMA/AAMA ESSENTIALS for accreditation of college-level medical assistant programs.
- Communicating your ideas regarding professional medical assistant practice so that the educational content may be continually updated.
- Supporting the position of Terrell Spencer, MD, published in his article, "The Medical Assistant and the Health Care Delivery System":

> "The professional medical assistant will increasingly become the key person in keeping a physician-patient relationship simple, honest, and meaningful in an ever-growing, complex medical organization."

By increasing physician efficiency and ambulatory health care cost-effectiveness, more patients can be helped more effectively in years to come.

(Please detach and save this page for handy reference.)

Michigan State Medical Society component society officers

Allegan County Medical Society — President: D. S. Sprague, MD, Allegan; Secretary: A. Gonzalez, MD, Med. Pathfinder Lab, Fennville, 49408

Alpena-Alcona-Presque Isle County Medical Society — President: C. R. Anderson, MD, Alpena; Secretary: Peter Aliferis, MD, Alpena General Hosp., Alpena, 49707

Barry County Medical Society — President: J. L. Weatherhead, MD, Hastings; Secretary: K. S. Merriman, MD, 1005 W. Green St., Hastings, 49058

Bay-Arenac-Iosco County Medical Society — President: Paul W. Rowe, MD, Bay City; Secretary: H. I. Blumenstein, MD, 1560 Kinney Ct., Essexville, 48732

Berrien County Medical Society* — President: J. A. Valantiejus, MD, Harbert; Secretary: Gideon D. Medina, MD, 115 S. St. Joseph, Niles, 49120

Branch County Medical Society — President: Donald Paarlberg, MD, Coldwater; Secretary: Frank W. Moler, MD, 292 E. Chicago St., Coldwater, 49036

Calhoun County Medical Society — President: L. E. Dorfman, MD, Battle Creek; Secretary: B. J. Cassin, MD, 175 College St., Battle Creek, 49017

Cass County Medical Society — President: A. G. Lira, MD, Niles; Secretary: Jashu N. Patel, MD, 515 Main St., Dowagiac, 49047

Chippewa-Mackinac County Medical Society — President: Hugh R. Allott, MD, Sault Ste. Marie; Secretary: Rassul S. Saber, MD, 500 Osborn Blvd., Sault Ste. Marie, 49783

Clinton County Medical Society — President: A. N. San Juan, MD, St. Johns; Secretary: W. F. Stephenson, MD, 510 E. Walker, St. Johns, 48879

Delta County Medical Society — President: Ali H. Sawaf, MD, Escanaba; Secretary: James W. Clay, MD, Rt. #2, Box 149, Gladstone, 49837

Dickinson-Iron County Medical Society — President: Wm. A. Belding, MD, Iron Mountain; Secretary: Ray S. Koivunen, MD, 1500 W. Ice Lake Rd., Iron River, 49935

Eaton County Medical Society — President: G. S. Stipanuk, MD, Eaton Rapids; Secretary: R. L. Leeser, MD, 210 W. Oliver, Charlotte, 48813

Genesee County Medical Society* — President: R. J. McMurray, MD, Flint; Secretary: R. M. Engelman, MD 2744 Flushing Rd., Flint, 48504

Gogebic County Medical Society — President: J. R. Franck, MD, Wakefield; Secretary: D. L. Davidson, MD, 200 S. Sophie, Bessemer, 49911

Grand Traverse-Leelanau-Benzie County Medical Society — President: Gene D. Tang, MD, Traverse City; Secretary: Arthur F. Dundon, MD, 1100 Sixth St., Traverse City, 49684

Gratiot County Medical Society — President: Kevin P. Foley, MD, Alma; Secretary: James K. Hall, MD, 160 Warwick Dr., Alma, 48801

Hillsdale County Medical Society — President: Arthur J. Stein, MD, Hillsdale; Secretary: Charles T. Vear, MD, 209 S. Howell, Hillsdale, 49242

Houghton-Baraga-Keweenaw County Medical Society — President: Peter E. Carmody, MD, L'Anse; Secretary: Gary M. Mikel, MD, 416 Tamarack St., Laurium, 49913

Huron County Medical Society — President: E. E. Steinhardt, MD, Bad Axe; Secretary: R. A. Willits, MD, 193 N. Main St., Elkton, 48731

Ingham County Medical Society* — President: R. C. Kinzel, MD, Lansing; Secretary: J. C. Spencer, MD, Edw. W. Sparrow Hosp., Lansing, 48902

Ionia-Montcalm County Medical Society — President: C. E. Stevens, MD, Greenville; Secretary: L. E. Sanford, MD, 302 S. Bridge St., Belding, 48809

Isabella-Clare County Medical Society — President: F. D. Johnson, MD, Mt. Pleasant; Secretary: J. M. Caldwell, MD, 314 S. Brown St., Mt. Pleasant, 48858

Jackson County Medical Society* — President: J. W. Wilkins, MD, Jackson; Secretary: L. E. Jennings, MD, 123 N. West Ave., Jackson, 49201

Kalamazoo County Medical Society* — President: E. J. Alberding, MD, Portage; Secretary: Fredk. W. Bald, MD, 402 Bronson Medical Ctr. Kalamazoo, 49006

Kent County Medical Society* — President: S. C. Bauserman, MD, Grand Rapids; Secretary: W. S. Stawski, MD, 1900 Wealthy St., SE, Grand Rapids, 49506

Lapeer County Medical Society — President: Merle B. Haney, MD, Romeo; Secretary: Leon R. Boruch, MD, 834 Liberty St., Lapeer, 48446

Continued on page 220

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When **impotence** is due to androgenic deficiency.

Android® /5 Buccal mg. /10 Oral mg. /25 Oral mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

COMPONENT SOCIETY OFFICERS/*continued*

Lenawee County Medical Society — President: Xenophon Skufis, MD, Adrian; Secretary: Nancy S. Newlin, MD, 710 W. Pottawatamie, Tecumseh, 49286

Livingston County Medical Society — President: S. L. Hoffman, MD, Howell; Secretary: C. A. Creighton, MD, 1200 Byron Rd., Howell, 48843

Luce County Medical Society — President: C. W. Dunn, MD, Newberry; Secretary: R. D. Gibson, MD, 207 W. John St., Newberry, 49868

Macomb County Medical Society* — President: G. G. Brueckner, MD, Mt. Clemens; Secretary: R. M. Kommel, MD, 26510 Dundee, Huntington Woods, 48070

Manistee County Medical Society — President: R. R. Knoblich, MD, Manistee; Secretary: A. F. Xavier, MD, 310 Ninth St., Manistee, 49660

Marquette-Alger County Medical Society — President: John M. Coyne, MD, Marquette; Secretary: J. F. Gephart, MD, 420 W. Magnetic, Marquette, 49855

Mason County Medical Society — President: J. E. Van Kuiken, MD, Ludington; Secretary: Gerry L. Mayer, MD, 806 Russell St., Ludington, 49431

Mecosta-Osceola-Lake County Medical Society — President: J. M. Wolschleger, MD, Big Rapids; Secretary: Leonard Reedyk, MD, 413 Mecosta Ave., Big Rapids, 49307

Menominee County Medical Society — President: Edw. J. Pienkos, MD, Menominee; Secretary: W. S. Jones, Jr., MD, 1146 Tenth Ave., Menominee, 49858

North Central County Medical Society — President: K. W. Waterfall, MD, Gaylord; Secretary: C. L. Gosling, MD, Fam. Practice Ctr., Rte 2, Grayling, 49738

Midland County Medical Society — President: L. C. Christensen, MD, Midland; Secretary: James H. Frye, MD, 1412 E. Wackerly Rd., Midland, 48640

Monroe County Medical Society* — President: Kanti H. Shah, MD, Monroe; Secretary: Ihsan U. Haq, MD, 905 N. Macomb St., Monroe, 48161

Muskegon County Medical Society* — President: J. W. Crawford, MD, Muskegon; Secretary: J. A. Leinicke, MD, Hackley Medical Ctr. #300, Muskegon, 49442

Newaygo County Medical Society — President: R. C. Clouse, MD, Fremont; Secretary: D. B. Reinders, MD, 230 W. Oak St., Fremont, 49412

Northern Michigan County Medical Society — President: C. A. Tressler, MD, Petoskey; Secretary: D. N. Mikhail, MD, Burns Clinic Med. Ctr., Petoskey, 49770

Oakland County Medical Society* — President: K. L. Urwiller, MD, Pontiac; Secretary: Michael Garcia, MD, 4400 Prud. Town Ctr. #275, Southfield, 48075

Oceana County Medical Society — President: V. Dale Barker, MD, Hart; Secretary: V. Dale Barker, MD, 17 Courtland St., Hart, 49420

Ontonagon County Medical Society — President: Steven N. Gervae, MD, Ontonagon; Secretary: Steven N. Gervae, MD, 511 Mors St., Ontonagon, 49953

Ottawa County Medical Society — President: L. E. Nelson, MD, Grand Haven; Secretary: Donald M. Fix, MD, 17950 Holcomb Rd., Grand Haven, 49417

Saginaw County Medical Society* — President: Jack L. Barry, MD, Saginaw; Secretary: Minoo K. Rao, MD, 5070 Overhill Dr., Saginaw, 48603

St. Clair County Medical Society — President: J. W. Copping, MD, Port Huron; Secretary: J. M. Murphy, MD, 1313 Stone St., Port Huron, 48060

St. Joseph County Medical Society — President: J. E. Phillips, MD, Sturgis; Secretary: T. E. Brenner, MD, 600 S. Lakeview, Sturgis, 49091

Sanilac County Medical Society — President: F. H. El-Ghazzi, MD, Sandusky; Secretary: R. I. Cutcher, MD, 2443 Black River St., Deckerville, 48427

Schoolcraft County Medical Society — President: John M. Clark, MD, Manistique; Secretary: Robert J. Urban, MD, 115 Lake St., Manistique, 49854

Shiawassee County Medical Society — President: Charles W. Webb, MD, Owosso; Secretary: D. F. Strong, MD, 1105 W. King St., Owosso, 48867

Tuscola County Medical Society — President: Maurice H. Chapin, MD, Millington; Secretary: Edw. J. Miles, MD, 261 Golfview, Caro, 48723

Van Buren County Medical Society — President: Larry G. Goss, MD, Bangor; Secretary: R. A. Farber, MD, 302 Harris St., Paw Paw, 49079

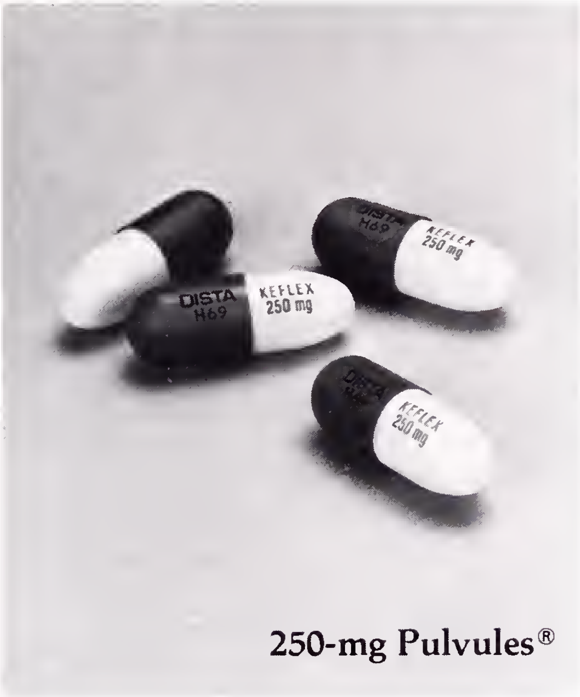
Washtenaw County Medical Society* — President: F. E. Patterson, MD, Ann Arbor; Secretary: L. H. Wolin, MD, 2216 Midford Rd., Ann Arbor, 48104

Wayne County Medical Society* — President: Kenneth J. Ray, MD, Trenton; Secretary: Susan E. Adelman, MD, 29820 Woodland Dr., Southfield, 48034

Wexford-Missaukee County Medical Society — President: R. D. Simmons, MD, Cadillac; Secretary: T. W. Tatarchuk, MD, 828 Oak St., Cadillac, 49601

**These counties have Exec. Directors or Exec. Secretaries*

easy to take



250-mg Pulvules®

Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes

Pediatric Drops

100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

the medical practitioner know, and can or should decide on the length and kind of education and academic preparation that professionals practice in these complimentary health professions is the continuing expression of arrogance and "self-centered" protectionism that has been a detriment to medicine and its reputation and image with the public for so long.

Medicine cannot solitarily meet the health and illness needs of all persons. When medicine (medical practitioners) recognize, appreciate, and willingly relate with other professional care givers who offer additional or alternative personal services, educational and counseling opportunities, prevention, screening, case-finding, therapeutic management and coordination of care — THEN a system of mutual respect, trust, and cooperation will have a chance to develop in which complete health and illness services can be provided.

Nursing does NOT advocate that nurses "practice medicine!" Nurses need academically-oriented education with a sound foundation of both scientific and behavioral arts courses precisely that they may competently "provide patient comfort, be alert to emergencies, and know when to call for expert medical help." (These are your words, and are no less true for medical education than for nursing education!) And we DO need "highly trained" nurses — nurses with advanced education beyond a generalist's basic entry preparation of a baccalaureate degree — to provide for care in the multiplicity of settings in which patients need health and illness assistance.

I urge you to personally explore the Nurse Practice Act of your state. And to read the definitions of professional nursing accepted by the American Nurses Association. And to talk with nurse educators whom you respect — in order that you might clarify the goals and roles of professional nursing. And, until you DO know and understand this contemporary context in which the professional nurse practices — it would be a courtesy to your fellow physicians to avoid arbitrary and uninformed opinion declarations.

Limitation of any practice discipline is a continually evolving and changing need for both societal examination and examination by the profession involved. Mutually respectful exploration of the differences, similarities, and points of complimentary services of medicine and nursing are greatly needed.

Such cooperative exploration cannot begin without a foundation of understanding based upon the integrity of the professions as they identify and appropriately claim their role and service and education. Your own statement "by the time the doctor arrives at the bedside, proper treatment has already begun" is an indication of your awareness of the close working relationships required between the professions for safe and adequate care for patients.

Claryce Swensen
Assistant Professor
Department of Nursing
College of St. Scholastica
Duluth, MN

PSROs' future

The following was sent to The Honorable Richard Schweiker, Secretary, US Department of Health & Human Services, late in February, and also to *Michigan Medicine,* for consideration by Doctor Johnson's colleagues.

Having been involved in the politics of organized medicine, as speaker of the house, president, secretary and member of The Council of The Michigan State Medical Society, having visited my congressmen and senators in Washington, DC, my state legislators and the governor of The State of Michigan over a span of 45 years as a practicing physician and some 30-plus years in organized medicine, I am well aware that personal contact is far more effective than any number of letters.

At present, I am chairman of a liaison committee specifically voted into being by The Michigan State Medical Society to be supportive of those members of The Society engaged in PSRO activities.

I am not acquainted with the degree of expertise you enjoy in this area. I only know that the press is quoting you as being in favor of repeal of the law which created PSRO's because insufficient money has been "saved."

I wish to emphatically call to your attention that there were two sides to the legislation creating this governmently(sic)-funded organization. One was, hopefully, to save money, but the other, and by far the most important, was to improve the quality of medical care.

I am sure that you are aware that medicine is constantly trying to improve on its product: the medical care of the public we serve. In my opinion this was one of the times when government and medicine, by combining desire and motivation and with guidelines spelled out, were partners in a common goal, a goal of inestimable value.

It is unfortunate that for a variety of reasons, some understandable and some ridiculously off-base, this program has not been well understood by many employees of government, physicians, hospitals, including, as you know, the AMA and AHA.

There are some of us (and we number many although we are not the great majority) who seem to appreciate that the program itself is not wrong, but the approach has been very much so. What I have chosen to call the "nickel and dime" approach has failed. There is however, what I have called the "big picture," to improve quality care, which I believe merits the continuation of the program, to the benefit of our country's citizens.

I hope you will modify your present position and if funding must be reduced in keeping with the big economy moves, that it will not be wiped out entirely. Please do your best to assist in improving the quality of medical care.

I might add that those of us who have been involved are hoping that private industry, such as insurance companies may be persuaded to get on the band wagon. We shall be working in that direction and hopefully let the government go back to governing.

Kenneth H. Johnson, MD
Lansing

P.S. Wish we had the money to come to Washington but things are tough all over.

No One Ever Sued Dr. Kildare For Malpractice

It's true. Back in 1962 when Dr. Kildare was one of television's most popular programs, millions of Americans would have been outraged. Richard Chamberlain and Raymond Massey almost always saved the patient and solved so many unusual diagnostic problems that they were our medical heroes.

And they did it without a CT scanner, an SMA 12, and all the other sophisticated technology which fills our hospitals today. Their patients loved them. Their viewers loved them. The drama flickering across America for 60 minutes each Thursday evening reassured us that our medical care was in good hands.

But this is 1981. The Age of Consumerism, Technology, and unfortunately. . . Litigation. US NEWS & WORLD REPORT stated there were 7 million lawsuits in 1978. That's one per every 30 Americans.

We still have our medical heroes. Quincy has been sued once for malpractice and he was an expert witness in another episode. Trapper John was also sued when he rendered emergency aid away from the hospital.

Times have changed. Society has changed. Medical skills, diagnostic expertise, and physicians' knowledge have increased significantly since the days of Dr. Kildare. Yet patients are suing physicians at a frequency which is alarming to the profession.

That's why in 1975, Michigan physicians chose to control their professional liability future by forming the Michigan Physicians Mutual Liability Company (MPMLC). A company owned, controlled, and totally supported by physicians.

MPMLC is your company. It is reacting to the 1980s by providing more coverages, reducing rates—the third reduction in the past four years, and responding to the needs of its insured physicians. Since issuing its first policy in May, 1976, MPMLC has become the second largest writer of medical professional liability coverage in Michigan. . .and the 25th largest in the country.

MPMLC is prepared for the Age of Litigation.

Michigan Physicians Mutual Liability Company

P.O. Box 1471
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926 toll free

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Your
Company

NEWS

By Bonnie L. Groff, MSMS staff

Henry L. Nadler, MD, chairman of the Department of Pediatrics at Northwestern University and chief of staff of Children's Memorial Hospital in Chicago, is new dean of the Wayne State University School of Medicine. Doctor Nadler, who will replace interim dean Lawrence Weiner, MD, takes his new post Sept. 1, 1981. . . . **Thomas Roth, MD,** director of Henry Ford Hospital's Sleep Disorders Center, has been named a committee member of the U.S. Surgeon General's National Program on Insomnia and Sleep Disorders. The purpose of the program is to improve public knowledge about sleep problems which affect some 50 million Americans. . . . **W. Donald Weston, MD,** dean of the Michigan State University College of Human Medicine, has been named by the American Medical Association's Council on Medical Education to serve on the task force deliberating the "Future Directions for Medical Education." . . . The United States Jaycees have selected **Thomas Carey, PhD,** Ann Arbor, one of America's Ten Outstanding Young Men for 1981. Doctor Carey found that the presence of tumor cells in the body sometimes triggers natural production of antibodies, suggesting that the body will be able to reject cancer cells once the proper vaccine is administered. . . . Michigan physicians appointed to commissions and committees by the American Academy of Family Physicians Board of Directors at the group's annual meeting include: **Douglass A. Haddock, MD,** Kalamazoo, chairman, Commission on Education; **Robert L. Vitu, MD,** Saginaw, Commission on Public Health and Scientific Affairs; **Charles R. Zimont, MD,** Constantine, chairman, Committee on Bylaws; **George A. Dean, MD,** Southfield, Public Relations Committee, and **Donald E. DeWitt, MD,** Kalamazoo, Committee on Scientific Program. . . . **Peter J. Cohen, MD,** Ann Arbor, is national president-elect of the Society of Academic Anesthesia Chairmen. The Society's primary purpose is to inform the general membership of research findings, developments in training programs, and other matters of interest to anesthesiologists. . . . **Laurence H. Baker, MD,** associate chairman and professor in the Department of Oncology at Wayne State University, has been named deputy director of the Comprehensive Cancer Center of Metropolitan Detroit, one of 21 major cancer research centers in the country. . . . The American College of Cardiology installed **Richard Judge, MD,** St. Joseph, as governor of the Michigan section at its annual scientific session in March. . . . **Marvin Rich, MD,** Detroit, is new chairman of the Board of Directors of the Ohio Valley-Lake Erie Association of Cancer Centers. The group is the largest regional association for cancer centers in the United States. . . . New vice president of the W. K. Kellogg Foundation is **Robert D. Sparks, MD,** Battle Creek. Doctor Sparks will work with senior vice president Andrew Pattullo in the area of program development and management across the three fields of grant-making interests; agriculture, education and health. . . . New Director of the Institute for the Study of Mental Retardation and Related Disabilities at the University of Michigan is **Herbert J. Grossman, MD,** Ann Arbor. . . . The Michigan Department of Public Health has presented a Certificate of Appreciation to **Fred Ayers, MD,** Daggett. The certificate was in recognition of Doctor Ayer's contribution to medical services, specifically his involvement in the development of an emergency medical technician training program in the Daggett-Menominee area. . . . **Arnold M. Weissler, MD,** Birmingham, has edited a new book entitled "Reviews of Contemporary Laboratory Methods." The book is a critical analysis of the scientific background, techniques and clinical application of the broad spectrum of diagnostic and research methods applied in modern cardiovascular laboratories.

Ahronheim

Carey

Nadler

Sparks

. . . **Edith Ahronheim, MD,** Jackson, was recipient of a Susan B. Anthony Award presented by the Jackson YWCA. Doctor Ahronheim was the first woman physician to work for the Michigan prison system. . . . **George A. Dean, MD,** Southfield, was quoted in an issue of *Family Practice News* from his address during a family practice residents' seminar. Doctor Dean stressed the need for representation by the Michigan Academy of Family Physicians on the Joint Commission on Accreditation of Hospitals and the need for a family practice department in every hospital in the nation. . . . The November issue of the *Journal of The American Medical Women's Association* carried an article by **Clara Raven, MD,** Detroit, entitled "SIDS — A New Perspective: Immunologic-mediated Pulmonary Disease." . . . **Steven G. Manikas, MD,** Ann Arbor, is the Grand Prize winner in the Medical Economics 1980 Awards for Best Original Articles by Physicians. His winning article was entitled "Even a Malpractice False Alarm Can Ruin You" and appeared in the December 8, 1980 issue. Another Michigan physician, **Rama Sekharan, MD,** Benton Harbor, received a Certificate of Award for his entry.

YOU'RE TOO PROFESSIONAL TO COLLECT BAD DEBTS.

THAT'S WHAT DEBTORS ARE COUNTING ON.

Debtors take advantage of professional people. Why? Because people with money problems know that most of you would rather take a loss than beg for your money. At I.C. System, we understand the dilemma. That's why we offer a uniquely professional collection service. I.C. System makes collections in an ethical, efficient and effective manner. Always with an eye to maintaining a professional image. Approved by some 1,000 state associations and societies all across the nation, including the Michigan State Medical Society, we are the only collection service specialized in working with professional and business associations. If you are interested in protecting your profits as well as your reputation, mail this today.

The System Works ®

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ______________________
Address ______________________
City ______________________
State ______________ Zip ________
Signature ______________________

Form No. 962

family practitioners

Seeking a board certified/eligible family practitioner to join family practitioner and general internist in a high quality growing practice in northcentral rural Wisconsin. Modern clinic building adjoined to community hospital. Call shared with two other physicians in a nearby community. Associate membership, then membership affiliation with a large multispecialty medical group 60 miles distant offering the full spectrum of consulting services and providing laboratory and administrative support and continuing medical education opportunities. Salary and fringe benefits excellent. Practice experience desirable but not mandatory. This is an excellent opportunity to exercise your talents in adult medicine, pediatrics, and OB-GYN in a small community environment practicing with skilled colleagues while enjoying a reasonable call schedule, freedom from business administration, and the security of ready access to consulting specialists in all fields. Send curriculum vitae and the names of persons who can be contacted for reference to:

FREDERIC WESBROOK, M.D.
Marshfield Clinic
1000 North Oak
Marshfield, WI 54449

MSMS seeks residents' ideas, interest

Resident physicians from around the state met with MSMS leaders early in March to describe young physicians' problems and goals. They also looked for ways in which MSMS could assist them and interest them in medical society programs. Meeting with MSMS Council Chairman Louis R. Zako, MD, left, are Charles Eckstein, MD, president, and Rhonda Gullett, resident coordinator, U-M House Officers Association, Ann Arbor.

"A NIGHT TO REMEMBER!"
From the Journal of the Speech-Language-Hearing Association

"Brilliant . . . the most distinguished work to open on Broadway this season."
NEW YORK TIMES

Patricia Fraser in

Wings

A Play by Arthur Kopit

Emily Stilson, a former stunt pilot, suffers a stroke and is plunged into a disoriented world. Her mind has short circuited and although she says, "I'm still intact in here," there's no contact with the outside world. But this is more than a play about a stroke and the battle to recover from it. It is about life and death and Emily is hauntingly suspended between the two.

LIMITED ENGAGEMENT! MAY 13-17
Wed-Fri 8:30 pm • Sat 2 & 8:30 pm • Sun 2 & 6:30 pm • $4.50 to $12.50

CALL (313) 963-7680
MasterCard or VISA • Also CTC Outlets • Group rates, 963-7622
Presented jointly by the Attic Theatre and Music Hall Center

MUSIC HALL CENTER
350 Madison Ave, Detroit — 3 Blocks from I-75
ATTENDANT PARKING • COCKTAIL LOUNGE • LIGHTED LOTS

An investment strategy for the 80's

By David M. Buegeleisen, Southfield

Over the years the successful investor has had to change his investment strategy to deal with changing economic realities. The three criteria which a successful investor uses to judge any investment strategy are: 1) What will my net return be after taxes? 2) What will this net return buy me? 3) Is the net return worth the risk?

From the late 1940's through 1968, common stocks were the investment vehicle which showed the greatest appreciation. Since 1968, however, common stocks have been a poor investment, while precious metals and collectibles, i.e. art, diamonds, rare stamps, coins, antiques, etc., have shown substantial gains.

60's spiral

With the advent of the inflationary spiral which began in 1966, successful investment policy was directed towards protecting purchasing power of the invested funds. Shrewd investors perceived that until the inflationary spiral was brought under control, the rate of inflation would increase each year. They would look for assets which would appreciate because of their scarcity value, increasing in price at a rate greater than that of inflation. Thus, collectibles became the successful investments of the 70's and relatively scarce commodities also were attractive areas of investment.

Borrowed funds were used to make purchases since the interest expense was tax deductible. And since they could be repaid with dollars of lesser buying power, leveraging became attractive. The high leveraging factor in most real estate purchases made this an attractive investment area.

During the late 60's when inflation was beginning to heat up, the tax on capital gains was increased substantially. In 1969 the maximum tax on capital gains was increased from 25 percent to 49 percent. This increase, along with the inflationary spiral, discouraged investors from taking the risks of investing in common stocks.

By the end of the 70's, the fashionable investments had become: Collectibles as a hedge against inflation, tax shelters to avoid the tax collector's greedy grasp, and short term money market funds to avoid the uncertainties of stagnation and inflation.

Since inflation and taxes have been the two major forces which effected investment philosophy during the 70's, let us look at their current status. As of November of 1978, capital gains taxes were reduced to a maximum of 28 percent although the holding period was increased from six months to one year. There are now, before Congress, any number of proposals to further reduce the long-term capital gains maximum rate to 18 percent to 22 percent.

Inflation peaking

Although inflation continues at extremely high levels, we are beginning to see some evidence that inflation has reached its peak and now may be ready to abate. It is this writer's opinion that the presidential election of last November was a mandate to end the inflationary spiral which has entrapped us. The American people are beginning to recognize the high social and economic costs of inflation and appear willing to make the sacrifice necessary to bring inflation under control. Implicit in any program to control inflation is the acceptance of a reduced rate of growth for the economy.

Ever since Nov. 4, the Federal Reserve Board has made substantial and determined effort to get the growth in the money supply under control. Since inflation is defined as "too much money chasing too few goods and services," this reduction in the growth of the money supply is of paramount importance.

The Reagan administration appears to be determined to attack the other side of the problem; that is, the supply of goods and services. It is doing so by adopting a tax policy designed to increase the incentive to produce more goods and services. It also appears determined to eliminate government regulations which are impeding increased production. At the same time, it is attempting to bring the federal budget under control so that the treasury will not be competing in the open market for lendable funds.

Mr. Buegeleisen is a private investment counselor and a fellow of the Financial Analysts Federation.

Evidence that the rate of inflation may well be declining is seen in the substantial drop in commodity prices and particularly in precious metals. Under the impact of high interest rates, real estate prices have started to decline in many areas of the country. The rise in value of the dollar against virtually every other currency in the world demonstrates a confidence that we are succeeding in ending the inflationary spiral of the past 15 years. This has all occurred since the election. These are subtle signs of a declining rate of inflation.

Stocks, bonds

If indeed we are leaving an era of high taxes and inflation rates, and entering a period without these two impediments, then successful investment policy must be directed at taking advantage of this change. The greatest beneficiary of this changed environment could well be financially denominated assets such as stocks and bonds.

Historically, interest rates have reflected inflation rates. The Federal Reserve Bank of St. Louis has done extensive research which demonstrated that, in general, interest rates will be approximately three percent above the rate of inflation. Thus, if the rate of inflation were to decline, it would be reasonable to expect interest rates to decline. Certainly, $1 of dividend income is worth more when readily available interest rates are eight percent than it is worth when these rates are over 16 percent. Also, a bond yielding a fixed rate of return is worth more when inflation and interest rates fall.

Since very few companies pay out all their earnings in dividends, the retained portion is added to the productive base which should increase the future stream of both dividends and earnings. At times of low interest rates, this future stream of earnings becomes most valuable. In addition, if the maximum tax on dividends is lowered to 50 percent, dividends have a greater after-tax value than if they are taxed at the current maximum rate of 70 percent.

If the program to slow inflation is successful and we enter a period of slow growth, then the economy will not need large sums of money and liquidity; therefore, money will flow into investments.

Investment opportunity

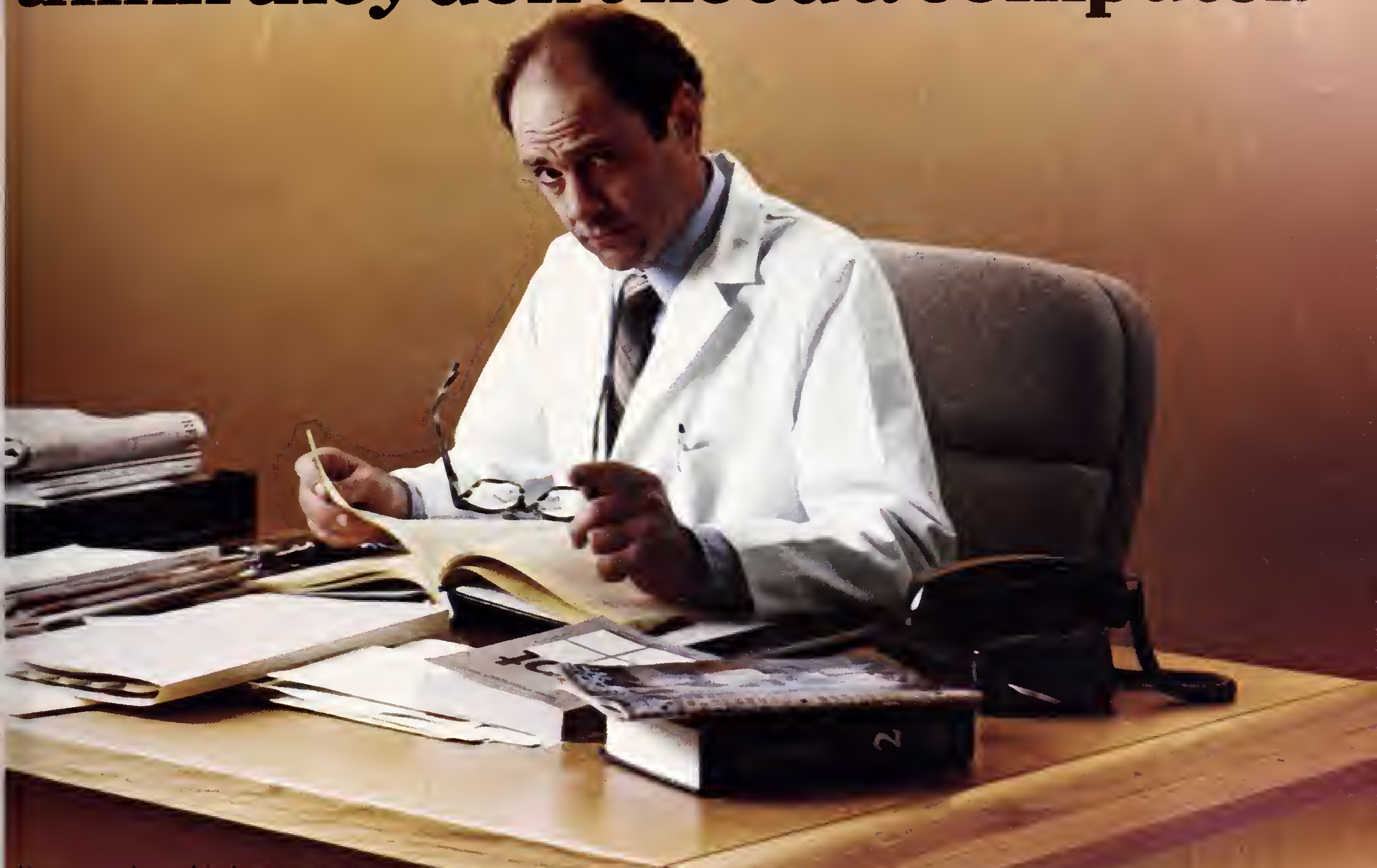
Enormous pools of capital have been built up which are seeking permanent investments. Two examples are the money market funds which now have assets of over $100 billion, and pension funds which have total assets of approximately $450 billion. Thus, if inflation were to abate and we were to have any further tax cut, it is evident that the funds to fuel a substantial stock market move are readily available.

For this hypothesis to be proven valid, precious metal and commodity prices must not rise. If they were to rise, that would be an indication that inflationary expectations were on the rise. Also, interest rates must not fall too precipitously. If they were to fall too precipitously, that would be an indication that the government intended to stimulate the economy and we would have a re-run of the stagflation scenario of the 1970's. If the changes in economic environment, which are outlined above, were to come to pass, the final risk-reward relationship would, for the first time since 1966, be heavily weighted in favor of the holder of common stocks. Thus, we could be approaching a rewarding investment opportunity.

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
Since 1899
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

DETROIT OFFICE
R. K. Wind, J. K. Galloway, T. A. Weisman, and W. M. Backus, Representatives
6785 Telegraph Road, Suite 350, Birmingham 48010
Telephone (313) 647-6640
GRAND RAPIDS OFFICE: G. J. Haworth, Representative
143 Cortland Avenue, Rockford 49341, Telephone (616) 866-9395

We're looking for doctors who think they don't need a computer.



Because they think a computer is too expensive.

The Sequoia Medical System™ can pay for itself:
- Increased collections
- Decreased receivables
- Improved staff efficiency

Because they think they already have firm control of their billing.

The Sequoia Medical System automatically processes billing paperwork:
- Patient statements
- Third party claims
- Collection letters

Because they think they have easy access to vital practice data.

The Sequoia Medical System provides information immediately:
- Aged receivable reports
- Procedure and diagnosis analysis
- Daily production and revenue analysis
- On-line access to 4½ million medical journal articles in the National Library of Medicine
- And many other forms of essential data

Because they think a computer is administratively disruptive.

The Sequoia Medical System is designed to blend smoothly into solo and small group practices:
- Easy to use
- Pre-programmed, turn-key system
- Includes training, installation, local service and support.

Because they haven't seen a Sequoia Medical System.

Sequoia can provide more time for health care in your practice. While it's taking care of business . . . you're taking care of patients.

Start looking into the benefits of a computer today by calling Sequoia Group. Call toll free (800) 227-2360; in California (800) 772-2655 . . . or write for our brochure.

SEQUOIA GROUP™
INCORPORATED
1100 Larkspur Landing Circle, Larkspur, CA 94939
Atlanta, Birmingham, Boston, Buffalo, Charlotte, Chicago, Cleveland, Columbus, Dallas, Denver, Detroit, Hartford, Houston, Indianapolis, Irvine, Kansas City, Los Angeles, Memphis, Miami, Minneapolis, Nashville, New Orleans, New York City, Norfolk, Oklahoma City, Philadelphia, Phoenix, Pittsburgh, Portland, Salt Lake City, San Diego, San Francisco, Seattle, St. Louis, Tampa, Washington, D.C

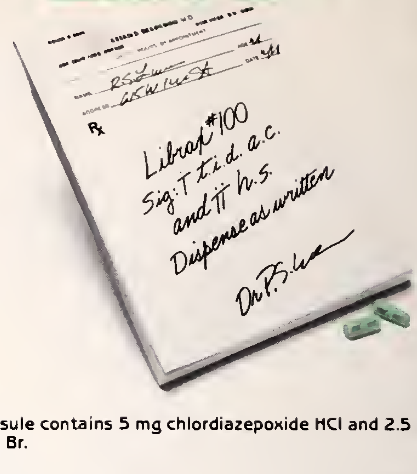
Ready to teach home nursing, first aid, parenting, child care, water safety, CPR.

Red Cross:
Ready for a new century.

1881
1981

A Public Service of This Magazine
& The Advertising Council

Specify
Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving) Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug

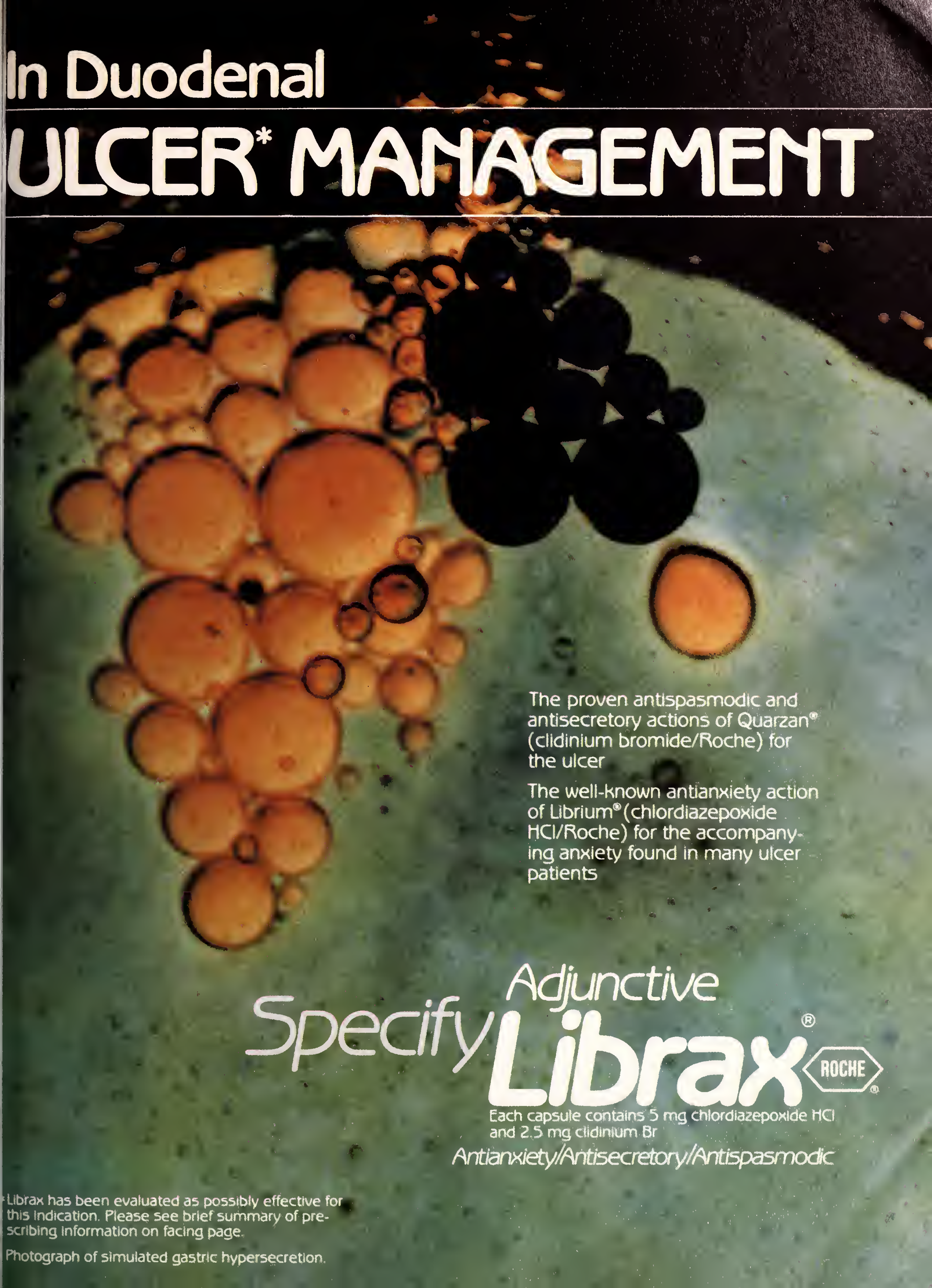
> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated) Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges Syncope reported in a few instances Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy Adverse effects reported with Librax typical of anticholinergic agents, i e , dryness of mouth, blurring of vision, urinary hesitancy, constipation Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

ROCHE®
Roche Products Inc
Manati, Puerto Rico 00701



In Duodenal

ULCER* MANAGEMENT

The proven antispasmodic and antisecretory actions of Quarzan® (clidinium bromide/Roche) for the ulcer

The well-known antianxiety action of Librium® (chlordiazepoxide HCl/Roche) for the accompanying anxiety found in many ulcer patients

Adjunctive

Specify Librax® ROCHE®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

Antianxiety/Antisecretory/Antispasmodic

*Librax has been evaluated as possibly effective for this indication. Please see brief summary of prescribing information on facing page.

Photograph of simulated gastric hypersecretion.

Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.

5
40
35
30
25
20
1
getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate® Dospan® Ⓒ IV

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate–it makes sense.
And it's responsible medicine.**

Merrell

Tenuate® Ⓒ IV
(diethylpropion hydrochloride NF)

Tenuate Dospan® Ⓒ IV
(diethylpropion hydrochloride NF)
controlled-release
AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states Patients with a history of drug abuse During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result)

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe There are reports of patients who have increased the dosage to many times that recommended Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia *Use in Pregnancy* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks *Use in Children* Tenuate is not recommended for use in children under 12 years of age

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias Tenuate should not be administered to patients with severe hypertension Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen Tenuate may decrease the hypotensive effect of guanethidine The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride *Central Nervous System.* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses In a few epileptics an increase in convulsive episodes has been reported *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances *Allergic* Urticaria, rash, ecchymosis, erythema *Endocrine* Impotence, changes in libido, gynecomastia, menstrual upset *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride). One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger Tenuate Dospan (diethylpropion hydrochloride) controlled-release One 75 mg tablet daily, swallowed whole, in midmorning Tenuate is not recommended for use in children under 12 years of age

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states Fatigue and depression usually follow the central stimulation Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of January, 1980

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633
Direct Medical Inquiries to
MERRELL DOW PHARMACEUTICALS INC.
Subsidiary of The Dow Chemical Company
Cincinnati, Ohio 45215
Licensor of Merrell®

References: 1 Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215 2 Hoekenga, M.T. et al: A comprehensive review of diethylpropion hydrochloride In Central Mechanisms of Anorectic Drugs, S Garattini and R. Samanin, Ed., New York Raven Press, 1978, pp 391-404

1-6847 (Y257C) MNQ-594

PRINTED IN U S A

Fiscal responsibility a part of good medicine

By William T. Rice, MD, Saginaw

CO$T EFFECTIVE MEDICINE

Blue Pencil sketch

This is the first response of individual physicians to a call from R. Jack Chase, MD, Grand Rapids, chairman MSMS Task Force on Medical Care Costs. Doctor Chase asked for ideas on containing medical care costs.

In the March 1981 issue of *Michigan Medicine*, R. Jack Chase, MD, chairman, MSMS Task Force on Medical Care Costs, cites the topics of five practical guidelines published by his committee for medical care cost awareness:

1) Diagnostic testing,
2) Pre-admission testing,
3) Discharge planning,
4) Outpatient surgery program,
5) Cost savings in surgery.

It's remarkable that Doctor Chase does not mention physicians' fees, which in these days of third party payments, is a problem not always immediately apparent to patients — unless they have to pay above and beyond the insurers' standard fee.

The state of Michigan is in a severe economic depression. The automobile industry is on its knees and is dragging its suppliers and dependent businesses down to the floor with it. Most of the health insurers derive most of their fees directly or indirectly from these industries. A few years ago GM was paying more than $1 billion a year for health benefits for employees world-wide. God knows what they are paying now.

With the high rate of unemployment in Michigan, many thousands of people will soon lose their third party health insurance coverage.

Doctors should not delight in the hardships and discomfiture of these people. We tend to blame them for the plight of the auto industry, failing to realize that we, the medical profession, have contributed as much to this problem as have the workers.

Any doctor willing to work 40 hours a week can make a pretty good living. Of course, if he must have a Mercedes or Datsun 280Z, a $150,000 home, a boat, country club memberships, and the life style of a wealthy prince, then this would be difficult.

Padding the bills, charging for every little procedure, pushing the insurance companies for yearly fee raises when many fees are already unreasonably high, and campaigning for unending increases in hospital building and equipment is past the lunatic stage in American medicine.

No one complains more than medical professionals when they have to pay extra for medical care. And I doubt they ever pay more than the Blue Cross-Blue Shield fee — unlike ordinary victims who are hit with extra charges by subscribing and non-subscribing doctors alike.

Blue Shield now pays $55 for a subclavian catheter, $433 for colonoscopy, $230 for gastroscopy, and $47 for sigmoidoscopy. And in this crazy scheme of things many doctors are paid more for these procedures, which anyone interested in learning can do, simple procedures that can be done in a very short time by a competent practitioner.

Is there no way that MSMS can attack this problem and save us from the horrors of state medicine and of government or Blue Cross-Blue Shield-sponsored HMOs?

Greed is killing the medical profession. We deserve to be finished off unless we realize in this changing world that we are doctors first and that fiscal responsibility is a part of good medicine.

Doctor Rice is a general and vascular surgeon in private practice.

"EVERY AGE HAS ITS PLEASURES, ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

PAVABID® AND PAVABID® HP

(papaverine hydrochloride)

150-mg Capsules 300-mg Capsulets

Patient benefit products from

PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY MO 64137

6/80

How your MSMS membership dues compare with other state societies'

How do MSMS dues compare to those of other state medical societies? They are a bit above the median, according to the tables provided here by the AMA's Office of Medical Society Relations. MSMS members are encouraged to study the tables for further information.

State Medical Society Dues in Order of Amount

Rank		Amount
*1.	District of Columbia	$495.00
2.	Wisconsin	380.00
3.	Alaska	350.00
4.	Idaho	345.00
5.	Colorado	310.00
6.	Arizona	300.00
7.	Maine	300.00
8.	Montana	300.00
9.	South Dakota	300.00
10.	Wyoming	300.00
11.	Hawaii	297.00
12.	Minnesota	290.00
13.	Iowa	275.00
14.	Pennsylvania	275.00
15.	Washington	273.00
16.	Michigan	260.00
17.	California	250.00
18.	New Jersey	250.00
19.	West Virginia	250.00
20.	Utah	245.00
21.	Maryland	230.00
22.	Georgia	225.00
23.	Kentucky	225.00
24.	Arkansas	225.00
25.	New Hampshire	225.00
26.	Nebraska	220.00
27.	South Carolina	220.00
28.	Oregon	212.00
29.	Mississippi	210.00
30.	Delaware	205.00
31.	Illinois	203.00
32.	Louisiana	200.00
33.	Massachusetts	200.00
34.	New York	200.00
35.	North Dakota	200.00
36.	Texas	200.00
37.	Ohio	295.00
38.	Indiana	181.00
39.	Oklahoma	180.00
40.	Alabama	175.00
41.	Florida	175.00
42.	Rhode Island	175.00
43.	Nevada	160.00
44.	Vermont	160.00
45.	Connecticut	150.00
46.	Kansas	150.00
47.	New Mexico	150.00
48.	Virginia	150.00
49.	North Carolina	140.00
50.	Puerto Rico	140.00
51.	Tennessee	130.00
52.	Missouri	115.00

Median Dues 1981 — $220.00
1980 — $200.00

*Medical Society of District of Columbia functions as both State and County Medical Society.

Membership Size
(State Society Members — 1980 count)

Size	Number of States	Range of Dues	Median
Under 2,000	18	$150-$350	$225
2,000-4,999	19	$115-$495	$220
5,000-9,999	7	$140-$290	$250
10,000-14,999	5	$175-$275	$200
15,000-19,999	0	—	—
Over 20,000	2	$200-$250	$225

State Medical Associations' Dues by Geographic Region

Geographic Region	Number of States	Range of Dues	Median
New England	6	$150-$300	$212.50
Mid Atlantic	3	$200-$275	$250.00
East North Central	5	$181-$380	$203.00
West North Central	7	$115-$300	$220.00
South Atlantic	9	$140-$495	$220.00
East South Central	4	$130-$225	$192.50
West South Central	4	$180-$225	$200.00
Mountain	8	$150-$345	$300.00
Pacific	5	$212-$350	$273.00

Self-insurance saves you money, but it needs the care of a money manager.

Many hospitals have found significant savings in self-insuring their malpractice coverage. In fact, in-hospital coverage of workmen's compensation and other employee benefit programs such as dental, health, disability and group life insurance has dramatically increased the use of self-insurance in medical institutions.

Proper administration of a self-insurance program, however, needs the services of an experienced investment manager, Detroit Bank & Trust.

We've served Michigan residents for over 130 years and rank as one of the largest trust institutions in the midwest. Our outstanding record as a manager of fixed income securities and our extensive experience in administering employee benefit programs have led many hospitals to choose us as their investment manager for self-insurance plans.

If you would like more information on how we can help you with your self-insurance or employee benefit programs, call or write Terry Keating, Vice President, at (313) 222-3898, Detroit Bank & Trust, Box 59, Detroit, Michigan 48232.

Self-insurance is not your most important job, but managing your money better is ours.

DETROIT
BANK
& TRUST

Member FDIC

Principal Trust Offices in
Detroit • Birmingham • Gaylord

Mr. Terrence E. Keating, Vice President
Detroit Bank & Trust
Post Office Box 59
Detroit, MI 48232

Please contact us in regard to administering our self-insurance program.

Name____________________Title_______________

Hospital___________________________________

Address___________________________________

City_______________State_________Zip_______

Telephone____________________

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Donald R. Anderson, MD AN
16001 W. Nine Mile Rd.
Southfield, 48037

Joseph A. Arends, MD GPM/AM
1551 W. Big Beaver Rd.
Troy, 48084

George F. Ascherl, MD DR
1900 Columbus
Bay City, 48706

Ralph A. Babcock, MD IM
6114 Ledgeway Dr.
West Bloomfield, 48033

Rakesh Bhutani, MD IM/ON
16001 W. Nine Mile Rd.
Southfield, 48075

Eldon E. Cassell, MD PTH
811 N. Kelly
Hastings, 49058

Edward M. Cohn, MD OPH
3535 W. 13 Mile Rd. #601
Royal Oak, 48072

Walid Demashkieh, MD GS
1225 10th St.
Port Huron, 48060

Bruce R. Deschere, MD FP
29180 Sharidale Rd.
Southfield, 48034

Khalil Dirani, MD AN
32950 Five Mile Rd.
Livonia, 48154

David H. Forst, MD CD/IM
44199 Dequindre
Troy, 48098

Harold D. Friedl, MD CRS/GS
2401 Gull Rd.
Kalamazoo, 49001

Miguel G. Gatmaitan, MD FP
23700 Orchard Lake
Farmington Hills, 48018

Robert D. Harris, MD GS
22480 Kelly Rd.
East Detroit, 48021

Gary M. Herzler, MD DR
3406 Davenport
Saginaw, 48602

Michael T. Heuton, MD GS
3800 Woodward Ave. #612
Detroit, 48201

Carlos J. Huanes, MD AN
11800 12 Mile Rd.
Warren, 48093

Yoo S. Hwang, MD TR
211 Bronson Medical Ctr.
Kalamazoo, 49006

John M. Joliat, MD IM
3739 Ravena
Royal Oak, 48072

Joseph W. Kaufman, MD D
29373 Birchcrest Way
Farmington Hills, 48018

Jason Y. Kim, MD FP
390 E. Maple St.
Climax, 49034

Mark S. Kinziger, MD OPH
3535 Park St. #111
Muskegon, 49444

Sharon K. Knepfler, MD PD
11885 E. 12 Mile Rd. #100B
Warren, 48093

James Kohlenberg, MD IM
26505 John R
Madison Heights, 48071

Steven M. Korotkin, MD IM
29829 Telegraph Rd. #200
Southfield, 48034

John LeClaire, MD PM
1700 Clinton Ave.
Muskegon, 49442

Harry A. Mahannah, MD P/CHP
1201 W. Oakland
Lansing, 48915

Walter G. Maurer, MD IM
215 E. Mansion St.
Marshall, 49068

Robert M. McNier, MD GE/IM
1811 N. Michigan
Saginaw, 48602

Daniel F. Merges, MD EM
2130 Godwin, S.E.
Grand Rapids, 49507

Nagaprasad B. Murthi, MD P
4116 W. Maple Rd.
Birmingham, 48010

Vic A. Oraegbu, MD GS
1214 N. Ballenger Hwy.
Flint, 48504

Hussein H. Panju, MD IM/GE
22041 Shadybrook
Novi, 48050

Jeffrey T. Perrapato, MD CDS/TS
1634 Gull Rd.
Kalamazoo, 49001

Benjamin A. Perry, MD IM
252 E. Lovell #140
Kalamazoo, 49007

Jorge A. Quiroz, MD GS
435 Hickory St.
Milford, 48042

Seetaram Ravipati, MD R
2799 W. Grand Blvd.
Detroit, 48202

Larry F. Rawsthorne, MD IM/PUD
401 W. Greenlawn
Lansing, 48910

Evan J. Reinders, MD A/IM
1560 E. Sherman Blvd. #325
Muskegon, 49444

Jerome Rosenthal, MD RHU/IM
29255 Northwestern Hwy. #102
Southfield, 48034

Donald C. Ross, MD CHP/P
951 E. Lafayette Ave.
Detroit, 48207

Shahzad Sadiq, MD DR
19780 Hickory Leaf
Southfield, 48076

Robert S. Salamon, MD ORS/FP
29075 Wellington, E. A-13
Southfield, 48034

Kiritkumar S. Shah, MD FP
1020 York St.
Mt. Pleasant, 48858

Jacob N. Shanberge, MD PTH
3601 W. 13 Mile Rd.
Royal Oak, 48072

Michael C. Smith, MD GP
135 Lake St.
Roscommon, 48653

continued on page 240

There's always room for improvement... in your business communications. So call this toll-free number

1-800-482-2900

and ask about the "Business Improvements" brochure.

Nobody's perfect. And the very first step toward improving your business communications could be a toll-free call to 1-800-482-2900 right now! Just ask about the brochure "Affordable Business Improvements from Michigan Bell," which is yours at no obligation.

Improve your equipment!

This informative brochure suggests dozens of ways you can improve your business communications techniques in a wide variety of ways; for example, through up-to-date equipment such as Touch-a-matic® Telephones, Dialog™ Intercom Systems, Speakerphones, Com Key® key telephone Systems and Horizon® Communications System, the new computerized self-programmable system... to name just a few.

Improve your services!

There are services available that can put an end to missed business calls—services that let your calls follow you when you leave your office, and sales services that show you how to improve sales and collections, and streamline your marketing techniques.

Improve your out-of-town business!

The brochure tells you ways you can "branch out" without leaving town, through a telephone service called Remote Call Forwarding. Foreign Exchange Service gives you local access to any area of the United States. 800 Service is still another way to make it easier for customers to reach you in seconds.

Improve your data transmission system!

The Dataspeed® 40 Terminal is one of the most advanced terminals offered anywhere! And if you want a fast, economical way to talk to your computer, you'll want to know more about Teleprinter 43. And that barely scratches the surface of the Michigan Bell data developments that could readily improve your business.

To get this fact-filled brochure at no obligation call the toll-free number above, or mail the coupon.

Michigan Bell
Affordable Business Improvements From Michigan Bell

MICHIGAN BELL BUSINESS COMMUNICATIONS CENTER
Program Headquarters
101 Union Street
Plymouth, Michigan 48170

MM

Please send, without obligation to me, your brochure "Affordable Business Improvements from Michigan Bell."

Name Title

Company ( ) Area Code Business Phone No.

Street City State Zip

Michigan Bell

NEW MEMBERS/*continued*

Philip M. Sorensen, MD AN
16001 W. Nine Mile Rd.
Southfield, 48037

Lisa Beth Speck, MD IM
41935 W. 12 Mile Rd.
Novi, 48053

Douglas F. Strong, MD FP
1105 W. King St.
Owosso, 48867

William E. Taylor, MD EM
27 S. Prospect
Ypsilanti, 48197

George Tchirkow, MD GS/CRS
Henry Ford Hosp.
Detroit, 48202

K. V. Venkatasubramanian, MD IM/RHU
2799 W. Grand Blvd.
Detroit, 48202

LaVern V. Wolfgram, MD GP
850 E. Front St.
Traverse City, 49684

Rudi Ansbacher, MD OBG
U of M Med. Ctr. OBG Dept.
Ann Arbor, 48109

Keith D. Bailey, MD IM/ON
252 E. Lovell #54
Kalamazoo, 49007

Kenneth S. Berneis, MD FP
304 Dix St.
Otsego, 49078

Howard A. Brody, MD FP
MSU — Fam. Pract. Ctr.
East Lansing, 48824

Seshagiri R. Dandamudi, MD PD/A
154 West St.
Battle Creek, 49017

Kevin M. Holleman, MD FP
325 E. Centre St.
Portage, 49002

Hugh L. Davis, MD ON/IM
2799 W. Grand Blvd.
Detroit, 48202

Timothy L. Geerlings, MD OBG
200 S. Taft St.
Zeeland, 49464

John B. Johnson, MD FP
1904 Fairfield St.
Saginaw, 48602

Virginia L. Johnson, MD
317 Riverbend Dr.
Manchester, 48158

Aruna Kumari Kode, MD AN
549 Elm St.
Wyandotte, 48192

Thomas A. Kwyer, MD OTO
15212 Michigan
Dearborn, 48126

Patricia S. Lozon, MD AN
2101 E. 12 Mile Rd. #202
Warren, 48092

Iftikhar A. Malik, MD GE/IM
910 E. Lincoln Ave.
Ionia, 48846

Elisabeth Mathew, MD OTO
28303 Joy Rd.
Westland, 48185

James H. Mering, III, MD U
1414 W. Fair Ave.
Marquette, 49855

continued on page 242

"Quality" United States & Canadian Decimals Since 1958

CARLTON
NUMISMATICS, INC.

CAND
ANA

- Professional Numismatic Counseling
- Acquisition of Rare Coins
- Portfolio Management
- Investment Programs

via
I.R.A., Keogh & Pension and Profit Sharing
Retirement Plans

To receive your complimentary copy of our Current Price List and Descriptive Brochures, please write or telephone:

Bingham Center • Suite 1646
30700 Telegraph Road
Birmingham, Michigan 48010
313 / 646-8846

BUSINESS HOURS:
Wednesday - Saturday 10:00 A.M. to 3:00 P.M. and by appointment.

Life Members A.N.A., C.N.A., M.S.N.S.: Associate Members C.A.N.D.

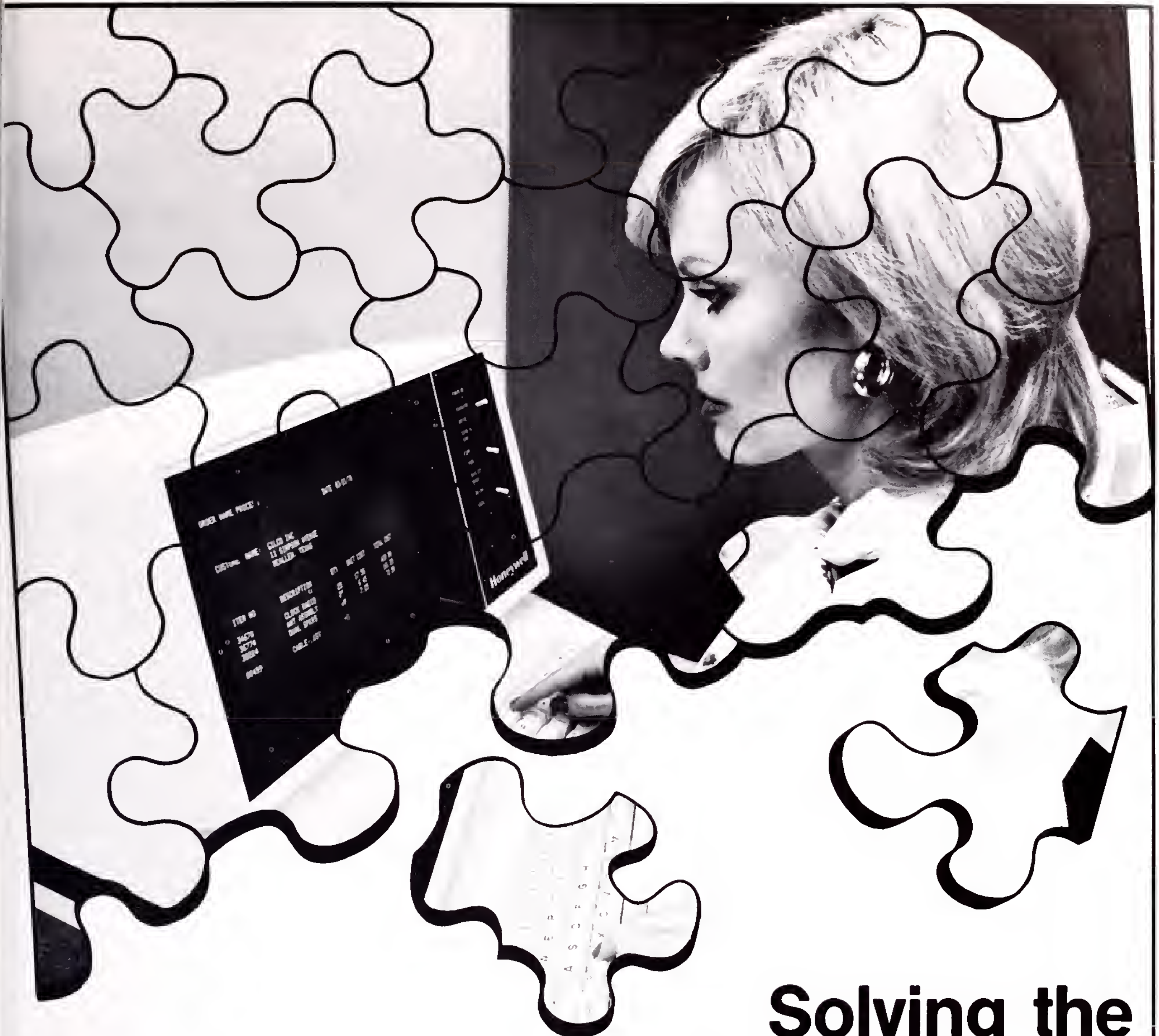
LOCUM TENENS

EMERGENCY MEDICAL POSITIONS

Emergency Consultants, Inc. has select opportunities in emergency medicine available on a locum tenens or full time basis. Positions in resort and recreational areas offer flexible scheduling, competitive hourly rates, and excellent benefits including malpractice insurance.

Emergency Consultants, Inc., a physician owned and operated corporation, currently services 60 hospitals in 12 states. Our organization accommodates professional and personal physician goals by providing a wide variety of locations with varying patient volume.

For further information contact: Emergency Consultants, Inc., Suite 115, 2240 South Airport Road, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.



Solving the Computer Puzzle

Purchasing an office computer system can be a time consuming and confusing process. Particularly when it comes to putting together all the "pieces" necessary for a smooth, trouble-free installation.

The Paradata/Honeywell Medical Computer System provides the modern medical office with an economical and productive means of "taking care of the paperwork" by offering the following components:

Hardware: The Honeywell Level 6 is a full function business computer designed to offer the most advanced electronic technology and growth capability available today.

Programming: Years of design and local field testing have been combined to provide a program package tailored to the specific needs of the Michigan doctor.

Training: Knowledgeable representatives will work with your operator until the fundamentals of efficient operations have been mastered.

Service and Maintenance: In-house service is provided by Paradata customer engineers. A periodic maintenance agreement is also available.

In short, our system is complete, installed, and offers all the "pieces" from a single source. It's the system engineered by professionals for professionals.

Para Data
OF MICHIGAN, INC.
3000 Town Center, Suite 2830, Southfield, Michigan 48075
(313) 352-3820

For more information, return completed coupon.

NAME

ADDRESS

CITY STATE ZIP

CONTACT ( ) PHONE

Demetrois N. Mermiges, MD FP
Henry Ford Hosp.
Detroit, 48202

Yagesh S. Mody, MD DR
1429 David Whitney Bldg.
Detroit, 48226

A. M. Mussani, MD IM
18600 Van Born
Woodhaven, 48183

Logan A. Oney, MD IM/ID
3990 John R.
Detroit, 48201

Ranjan D. Parekh, MD PTH/FP
10867 W. Jefferson
River Rouge, 48219

Lascelles Pinnock, MD OTO
1301 Orleans #411
Detroit, 48207

Usha B. Raju, MD PTH
Henry Ford Hosp.
Detroit, 48202

Frederick D. Rau, MD ORS
1215 Stone Henge
Flint, 48504

Gretchen H. Rooker, MD IM
19401 Hubbard Dr.
Dearborn, 48126

Maria A. Sawdyk, MD IM/HEM
Henry Ford Hosp.
Detroit, 48202

Robert M. Soderstrom, MD D/IM
G-5131 W. Bristol Rd. A
Flint, 48507

Richard E. Stiefler, MD D/P
Henry Ford Hosp.
Detroit, 48202

Barry D. Stringfield, MD I
770 Riverside Ave.
Adrian, 49221

Juan R. Swain, MD G
US Coast Guard Air Station
Traverse City, 49684

Gary B. Talpos, MD G
Henry Ford Hosp.
Detroit, 48202

John F. Walstrum, MD F
551 Linn St.
Allegan, 49010

V. K. Yeddanapudi, MD P
35070 Valley Forge
Farmington Hills, 48018

WILLIAM M. CAMERON, M.D.
For
℞
Herpecin-L
Lip Balm
Sig: q.h.
as needed
HERPECIN-L®

Dx: recurrent herpes labialis

OTC.
See PDR for
Product Information.

For samples, write:
Campbell Laboratories Inc.
P.O. Box 812-M, FDR Sta.
New York, NY 10150

In Michigan, "Herpecin-L" is available at all *Arnold, Muir, Cunningham* and *Perry Drug Stores* and other select pharmacies.

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN

Healthy Competition
Makes A Healthier Market

**Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.**

Occurrence Coverage

Choice of limits— $100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

MSMS Q/A

Questions on a wide variety of topics are asked daily of MSMS staff and leaders. They in turn draw on many expert resources to help MSMS members get good information. To better inform the membership, sample questions, with answers, are printed here. Future issues will carry more.

For: A. Stewart Kerr, Detroit
MSMS Legal Counsel

"In the face of the Federal Trade Commission's careful scrutiny of al medical society actions these days for any possible antitrust activity, is it prudent for a county medical society to audit the reasonability of a physician' fee?"

MSMS continues to receive requests to mediate or otherwise handle fee reviews and fee disputes. The Society's present procedure is to sen such requests directly to the county medical society of the physician who i involved. We find, however, that the fear of legal retribution by some government agency has become so pervasive that some of the component societies ar not interested in this public service.

This apprehension at the county level is understandable. Within recen years, the medical profession and other professions have been attacked fo promulgation of suggested target or suggested minimum fee schedules, relativ value scales, and discussions with third party carriers. Small wonder, therefore that there is nervousness about doing any peer review which involves fees Clearly, it is illegal for an association to enter into any activity which has th purpose or effect of raising, lowering, stabilizing or otherwise tampering wit prices. What then are the circumstances under which, generally speaking, component society may or may not concern itself with fee reviews?

The key question is whether the particular activity will have any effect or fees in that community for the service or procedure involved or whether th review pertains to an isolated fee or fee dispute, the resolution of which woul have no precedential value. Sometimes a medical society is requested by third party payer to evaluate the reasonability of the fee for a particular procedure in a specific case. If the third party payer plans to use the evaluation or settlement of the case as a precedent upon which to base its future payments i the community for that service, an unlikely circumstance, then the red warnin flag is up. If it is clear that the third party payer has no purpose in seeking th help save to resolve that particular, limited dispute, then there appears to be n problem.* Finally, if the dispute is simply one between the physician and dissatisfied patient, there isn't any antitrust exposure and it may safely be sai that a useful public service is being performed.

In performing these services, it is better to err on the side of safety. Hence it is wise to indicate that the fee in question is within a reasonable range or tha it seems a bit high. This is preferable to stating an exact dollar figure although again, there is no great danger in an ad hoc situation. Also, in each adjudication or mediation, all parties of interest should be notified that the only matte being decided by the committee is the applicability of that particular fee, t that patient, in that specific circumstance, and that the committee's ruling ha no value for any other purpose or precedent and should not be so construed.

*A well-known legal principle, recognized by Federal Trade Commission in its 197 proposed settlement decree for MSMS.

Put us to the test.

Send us a split specimen—at our expense—we'll prove our accuracy.

First, establish an account with us. It won't cost you anything. Then at your convenience, draw a specimen using accepted procedures. Divide it and submit it under wo names. When you receive the results, and you're satisfied they're statistically parallel, call us. We'll credit your account. It's that simple.

What else can you expect?

Quick results. We have three strategically located labs to provide routine test results within 24 hours, tissue results within 48 hours. Plus STAT service on some procedures.

Pickup and mail service. In many areas, our trained couriers will pick up your specimens. Outside our wide service areas, we provide prepaid mailing containers.

Quick-scan highlighted reports. Our reports were designed by pathologists. Abnormals are highlighted, making them easy to spot.

Staff pathologists. Abnormals are reviewed daily by our full-time staff pathologists. Any significant abnormal is immediately retested at no charge and the confirmed results phoned to you. Of course, our pathologists are available for consultation at any time.

Serum retention program. To make it easier for both you and your patient, every serum specimen is frozen for one week after initial testing. If further testing is necessary, just call us.

Accuracy assistance. We can assist you in training your personnel in laboratory procedures and proper specimen handling. Proper collection, handling and submission at your end further ensures accuracy at ours.

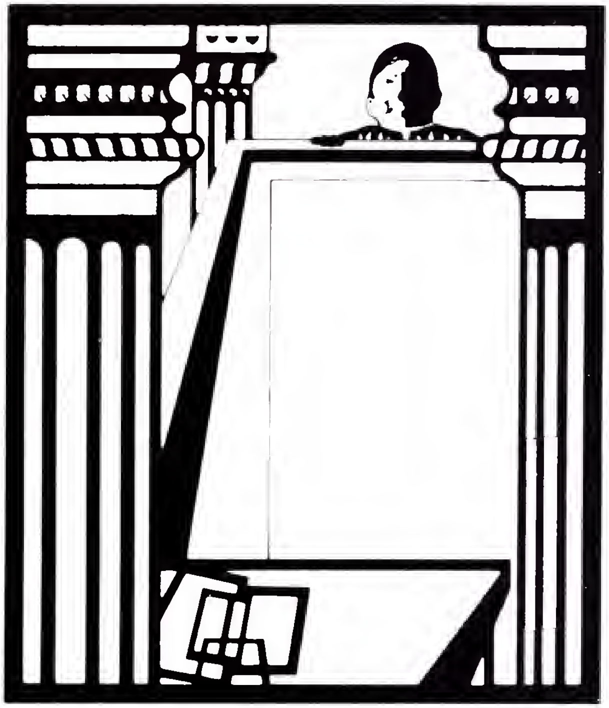
We're CBC and we've got a lot more to offer you. Our service is comprehensive, convenient, fast, and most important . . . accurate. Take the time to take our test. It may be one of the best things you ever do for your patients. And we *can* prove it.

To put us to the test call:
1-800-632-0706.

CBC
CONTINENTAL
BIO-CLINICAL
LABORATORY SERVICE, INC.
Grand Rapids, Michigan • Toledo, Ohio
Mishawaka, Indiana

Epidemic of suits hits lawyers

By Elmer White, special to Michigan Medicine



Malpractice suits among lawyers rose 250 percent between 1973 and 1978, reports "*Newsbriefs,*" newsletter for the State Bar of Michigan.

Some 30 percent of these cases result from simple errors involving missed deadlines, like filing dates, failure to appear in court, allowing the statute of limitation to pass without action. Others involve losing critical data, errors in drafting forms or filing in the wrong court. Average damage claimed is $150,000.

To avoid malpractice suits, lawyers are advised to set up better systems with reminders and cross-checks so they will keep on top of their responsibilities.

The Michigan medical malpractice situation resembles a volcano.

Just about everyone understands there is seething matter existing under substantial pressure; but there is considerable disagreement about when, if ever, there will be an eruption in the form of higher premiums. Experts also disagree on what should be done. In the meantime, clouds of smoke appear from time to time to obscure the issue.

John Richards, chief of the Bureau of Economics at MSMS, says that a big jump in insurance rates is inescapable. "The cost crunch will cause a blow-up," he says.

Gary C. Brown, vice president-risk management for Michigan Physicians Mutual Liability Company, disagrees. He points with some satisfaction to a new MPMLC schedule of rates which took effect January 1, 1981 with average overall decreases of 9.7 percent.

Michael Franck, executive director of the State Bar of Michigan, has little consolation for doctors in a discussion of malpractice matters — and only a few words of advice. These are the same, he emphasizes, as are his recommendations for lawyers, who are experiencing a substantial increase in the number of malpractice suits filed within their profession.

"Malpractice suits will be with us for a long time," says Mr. Franck, "and it is interesting to note that the tendency for clients to become dissatisfied is now spreading to other sectors of society, notably to lawyers."

"There is no substitute for a personal relationship," he emphasizes. "Prevention is better than any cure devised." He concedes it is sometimes difficult to cultivate a personal appreciation of "the other person's position" in medicine, but such appreciation can be an important goal — and it can reduce lawsuits.

"Admit errors when you realize something went wrong and try to rectify the situation," he advises. "Encourage the patient to see a lawyer," he adds with a straight face, suggesting that this will facilitate the settlement process.

"There is also no substitute for wise, careful practice," Mr. Franck admonishes his colleagues; and he believes this is just as true for members of the medical profession.

Countersuits are not the answe to problems caused by malpractice claims," says Mr. Franck. "They jus don't work!" Besides, he believes that the countersuit threatens a basic right of a United States citizen. "Does the patient with an arguable poin have a right to be heard?" asks th head of the lawyer's organization.

Mr. Franck points out there would be no end to the effect o countersuits. "If a doctor can sue lawyer who sues him and loses, ther is no end to the domino effect thi could have with one client or th other suing lawyers who lost." lawyers are sued when they don win, speculates Mr. Franck, then doc tors might have troubles findin lawyers for themselves.

The bar executive thinks som insurance companies play undesirable roles in the malpractice situation For one thing, they settle small cases too easily, he states, adding, "Even one of these can foster a group of ne and similar cases."

His rationale here seems to be that lawyers who must work hard o trivial cases will not be anxious get involved unless the evidence more solid. If such lawyers are pai as many are, on basis of a settleme and there is not likely to be a "good settlement, they will be careful wh suits they file.

Mr. Fronck

Some insurance companies make onsiderable profit from malpractice uits, suggests Mr. Franck, and omehow, this should be reduced. ust holding premium funds at present high interest rates permits them o turn a tidy profit from investment, he believes. Further, says Mr. Franck, nsurance companies no longer take isks so much as they act as clearing houses for settlements. The bigger he settlement bill, the bigger the in-urance premium they charge.

Mr. Brown, vice president of MPMLC, has his own strong views on these basic issues and they differ ubstantially from those of Mr. Franck. MPMLC, after just five years of existence, now insures some 40 percent of the state's MDs and DOs, nd is the second largest insurer in he state; the only Michigan insurer o employ a full time risk manager.

Emphasizing that this company s a mutual organization, he points out that when costs of settlements and other operations are reduced, insured doctors get the benefit by lower premiums. This undermines Mr. Franck's views about trying to make large profits from operation of an insurance organization.

Mr. Brown also cautions that there is "an alarming trend of increasing law suits and increasing severity of settlements; that the "long tail" effect (the period between the time the incident occurs and settlement, which averages 48 months) makes it difficult to predict what is down the road in malpractice.

He also points out that MPMLC has several programs underway which should reduce incidents. One of these is a "Residents' Information Kit," which is distributed to young doctors. It explains specific points about doctor-patient relationships which can help the medical profession. The insurance company also reviews through an underwriting committee consisting of six doctors what can be done to keep premiums reduced to the most reasonable level. "We try to help physicians get some control on this 'uncontrollable problem' in several ways," reports Mr. Brown. This includes identifying more information in general, the cause and effects of various procedures; and communicating this information to doctors. MPMLC has prepared audio-visual presentations for doctors, kits for insured doctors who must sign a statement that they have received the information, and numerous programs for younger doctors.

If doctors cannot change the malpractice arena in which they must operate, suggests Mr. Brown, they must then learn to use the best tools they have to function there . . . how to protect themselves, how to lower probability; how to ameliorate problems.

The whole area of malpractice has been sensationalized in media which feeds the problem, agree most observers. This trend has a number of disadvantages for the public.

John Anthony, general manager of the MSMS Physicians Service Group, says that one such result can be a reduction in availability of service in some areas because doctors will find it necessary not to offer certain procedures in order to keep themselves in a lower premium insurance category. Other doctors have been known to retire early rather than become involved in present programs or to refuse treatment to some, with the result that patients have to go long distances at great inconvenience to get what they might have had in their own localities were it not for the malpractice issue.

Costs of defensive medicine must be passed on to the public even though most patients do not understand this issue and how it contributes to over-all cost of medical treatment.

Michigan medical people operate in the state which has an unhappy record: million dollar verdicts are more common here than anywhere and getting larger. According to the *Low Journol* of Nov. 3, 1980, Detroit "may be the best town in the country in which to get a big jury award in personal injury claims."

At the same time, a study by Lou Harris in June, 1978, is considered to accurately reflect the situation today. This shows that a majority of Americans were quite satisfied with the quality of health care they receive.

Whether it seems fair to doctors or not that they should be subjected to some of the strains of malpractice issues, the strains are a fact of professional life. There are things which the medical profession can do to improve matters, and this is the course which offers most hope for a reasonable solution.

A word to the prudent physician

Since it is generally agreed that the threat of malpractice suits will be with us for a long time, there are a few things the prudent physician can do which will reduce the likelihood of trouble. The list is not long and it includes generalities. But these points, it is agreed by representatives of experts in the egal, medical and insurance fields, are important.

- **Routinely maintain the highest level of service possible for all patients at all times.**
- **Keep detailed records.**
- **Explain to patients the need for recommended procedures and the possibility, if any, for disappointing results.**
- **Make sure each patient understands what you have told him or her and show a willingness to repeat the information if you sense confusion about any aspect of the doctor-patient relationship.**
- **There is no substitute for an effective, personal relationship. As much as possible let patients know that you are concerned about them, their physicial and their emotional well being.**

Doctor-owned insurance companies may find tough times ahead

The two articles on this page are reprinted with permission from "Malpractice Lifeline" newsletter.

The day of reckoning for the doctor-created insurance companies is close at hand, warns an I-told-you-so insurance industry report.

In the face of 1980 reports showing a sharply rising combined loss and expense ratio and an underwriting loss nearing $3.5 billion (the second worst ever), for the property/casualty insurance business, *Best's Insurance Management Reports* earlier this month said these results appear to be "the prelude to worse things to come."

"The outlook for the insurance industry is that 1981 will be worse than 1980, producing a combined loss and expense ratio of 105 percent or higher, with record dollar underwriting losses," the respected insurance publication said.

Turning to liability in particular, *Best's* said, "If there was cause for panic in 1974, 1975, and 1976 over the loss ratios on some of the coverages in the general liability line, 1980 offers ample cause for turning on the alarms again. The liability coverages produced their largest loss in history last year — $870 million — as premium volume was static, while incurred losses rose 16.5 percent and the combined ratio moved up 11½ points. Medical malpractice was the chief culprit, showing a loss of $555 million on $1.1 billion of premiums, but the other coverages contributed a loss of nearly $315 million."

According to the *Best's* editors, medical malpractice has demonstrated its ability "to stun the underwriting departments." Since the great '70s crisis, the rewriting of most of this business, and the introduction of claims-made coverage five years ago, "experience has deteriorated drastically."

Last year's combined loss ratio for this line of business is thought to have soared by about 37 points to 154 percent, as the underwriting loss went over the $550 million figure. Even though premiums went up 14 percent to nearly $1.1 billion, incurred losses jumped 46 percent, nearly matching earned premiums, as the pure loss ratio hit 99 percent. In the six years that medical malpractice figures have been reported separately, there has been an underwriting loss of $960 million and a combined loss ratio of 116 percent.

Now, says *Best's*, somewhat pejoratively, the doctor-companies, "set up to save doctors and hospitals money because they had found a new way of doing business that would show up the greedy giant insurance industry — are having to come to grips with this problem. Reports of stiff rate increases abound."

Obscuring industry-wide fallbacks in property/casualty insurance, generally, the *Best's* experts point out, is high investment income. Were it not for inflation and high interest rates, the performance of the industry would be unacceptable.

However, warns the publication, even if investment income offsets 1981 losses, there's no certainty that the expected cyclic upturn toward profitability next year will develop. "The different economic, social, judicial and legislative conditions which prevail today could make it unlikely that the cycle will operate in a predictable manner," the report says, making additional premium income essential. But there is the increasing problem of competition and consumer resistance to more rate increases.

Calling 1981 a critical year for the liability insurance business, *Best's* says that both products and malpractice (not just in medicine but in other professional lines) have begun to turn sour. The attention not only of underwriters but of the legal departments and others who can contribute to the solution is going to be required.

"If another round of rate increases of the kind that were imposed in the mid-70s is necessary in the early '80s, it could set off medical cost increases that will be reflected in higher loss payments in automobile, workers' compensation, accident and health and other lines. Something more than a simple dollar answer is required."

California DES suit has Michigan ties

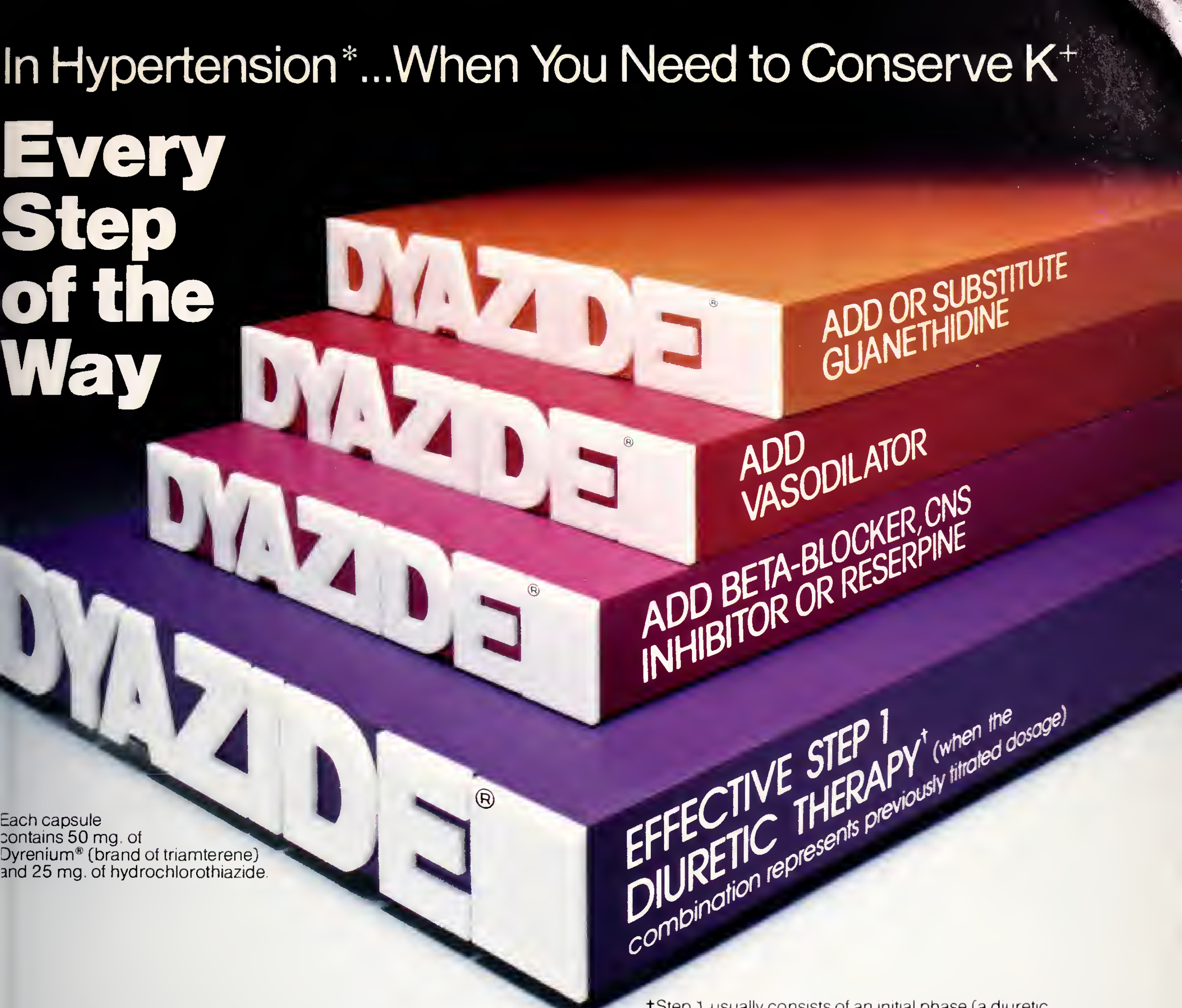
Product liability lawyers are closely watching diethylstilbestrol (DES) cases before the Michigan Supreme Court, in hopes that a ruling there eventually will nullify California's "landmark" decision on DES last May.

Their theory is that the US Supreme Court's refusal to review the California Supreme Court case favoring a "DES daughter" reflects simply a reluctance to involve itself in a state's laws — and that it might well agree to accept a similar case from another state. (Others last fall interpreted the high court's move as support for the California decision.)

"Each state will have to make its own decision," New York University law professor Sheila Birnbaum is quoted as saying in the *Wall Street Journal*. "The US Supreme Court declines many appeals. It could always accept a similar case for review in the future."

The Michigan case involves some 300 women whose mothers were prescribed DES a generation ago to prevent miscarriage. Only in recent years was it found that in some instances the hormone has been associated with cancer in their daughters. The California ruling for the first time faulted all major manufacturers of a product — in this case, five makers of DES — rather than requiring the plaintiff to prove particular company blame.

"That decision promises to affect not only thousands of similar drug suits but legal wranglings concerning countless other products as well," the December 30, 1980 *WSJ* report observed. "Already, numerous lawyers are testing the theory in other states or trying to stretch the ruling to its limits. Almost everyone agrees that decision represents a radical change in liability law."


In Hypertension*...When You Need to Conserve K+
Every Step of the Way
DYAZIDE®
ADD OR SUBSTITUTE GUANETHIDINE
DYAZIDE®
ADD VASODILATOR
DYAZIDE®
ADD BETA-BLOCKER, CNS INHIBITOR OR RESERPINE
DYAZIDE®
EFFECTIVE STEP 1 DIURETIC THERAPY† (when the combination represents previously titrated dosage)

Each capsule
contains 50 mg. of
Dyrenium® (brand of triamterene)
and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K+ supplement or K+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K+ supplement or K+-sparing agent).

Serum K+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. The following is a brief ummary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia Pre-existing elevated erum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency Periodically, erum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk If their use is essential, the patient should stop nursing Adequate information on use in children is not available Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded. in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine Hypokalemia, although uncommon, has been reported Corrective measures should be instituted cautiously and serum potassium levels determined Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium Chloride deficit may occur as well as dilutional hyponatremia Serum PBI levels may decrease without signs of thyroid disturbance Calcium excretion is decreased by thiazides 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

© SK&F Co., 1980

SK&F CO.
a SmithKline company
Carolina, P.R. 00630

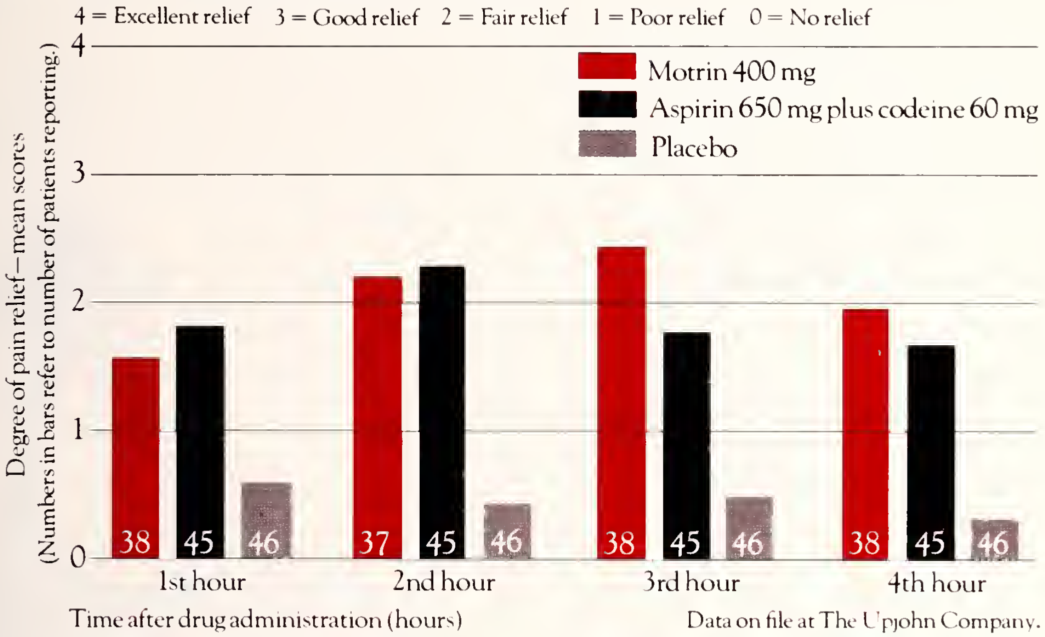
Motrin® vs aspirin w/codeine...
(ibuprofen)

©1981 The Upjohn Company

compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-4-S

J-8260-4

MARCH 1981

Send now for the only book on crime ever written by a dog!

Get hot tips on crime prevention from the Crime Dog himself! Me! Send for my book. It's got all the hit topics like: how to burglarproof your home, how not to get mugged, and more!

Write to:
McGruff™
Crime Prevention
Coalition,
Box 6600
Rockville,
Maryland
20850
and help.

TAKE A BITE OUT OF CRIME™

A message from the Crime Prevention Coalition, this publication and The Ad Council.

© 1980 The Advertising Council, Inc.

Ad Council

MEDICAL NEWSFRONTS

In response to Act 125 of the Public Acts of 1979, the Michigan Department of Public Health has instituted a clinical investigation of marihuana as an agent to control the nausea and vomiting associated with cancer chemotherapy under contract with the Michigan Cancer Foundation. To date, 77 physicians in 18 centers have enrolled in the project and approximately 135 patients have been included in the study.

A project to try marihuana as an adjunct in the treatment of glaucoma has recently been approved and implementation of the plan is being initiated.

EKG interpretations should be opened to all physicians who can demonstrate proficiency in accordance with the criteria established by the hospital's medical staff, strongly recommends the American Society of Internal Medicine.

ASIM's Institutional Relations Committee has developed new guidelines to assist hospitals and their medical staffs in organizing EKG interpretation services which are high in quality, readily available and cost effective.

In releasing its guidelines and recommendations, the ASIM emphasized it is not in the best interests of patients for qualified physicians to be denied the privilege of formal electrocardiogram interpretations.

For copies of the ASIM "Guidelines in Electrocardiogram Interpretation in the Hospital Setting," write or call ASIM at 2550 M Street, N.W., Washington, DC 20037, (202) 659-0330.

Two cases of Reye's Syndrome were reported to MDPH from Feb. 27 to March 26. A total of 20 cases, including one death, have been reported this season.

The first of these last two cases was an 11-month-old boy with a URI prodrome who made a rapid recovery.

The second was a seven-year-old boy with a mild URI and fever who initially presented for excessive lethargy. A peripheral blood smear revealed a high percentage of blast forms and a bone marrow confirmed the diagnosis of ALL.

A standard induction regimen was begun, following which the child developed vomiting and behavioral abnormalities which were originally attributed to the effects of chemotherapy and acute steroid-induced psychosis.

These were initially treated with phenothiazines, but a liver profile revealed enzyme abnormalities typical of RS. The child's condition rapidly deteriorated and he died three days after the diagnosis of RS was made.

This case should serve to remind us that Reye's Syndrome should always be considered when its symptoms are present, even when there are other likely explanations.

Reye's Syndrome activity continues to be low throughout the Great Lakes Region. Ohio reports 36 cases this year, including so-called stage 0 cases. Neither Wisconsin nor Minnesota has had recent cases. Influenza cases also continue to decline throughout the region and it looks as if the worst has passed.

PCBs in their milk need not cause the vast majority of new Michigan mothers to modify their breast feeding practices. That's the recommendation of the State Health Department's Select Panel on PCB's in Breast Milk which issued its report today. The Panel was convened by the Department in February to review its position on breast-feeding and PCBs.

According to the panel, there is no reason for most Michigan women to have their breast milk tested for PCB. The levels of PCB in almost all are known to average between one to two parts per million (ppm), but at these levels, the panel said, there is no evidence of any adverse health effects for human infants.

However, the panel did recommend that women who have been exposed to unusually high levels of PCB should have their breast milk tested. They include those employed for years in activities involving handling PCB; those involved in PCB incidents such as farm women exposed through contamination of meat and dairy products by a sealant containing PCB used inside silos; and those who for many years ate more than one meal a week of sports-caught fish from the Great Lakes or certain of its tributaries.

Such women, the Panel said, may have PCB levels over 10 ppm, in which case they should not breast feed at all. If the levels are between five and 10 ppm, the Panel said, women should discuss with their physicians modifying breast feeding practices.

The Panel noted that except for heavy occupational or other exposure, there appears to be no evidence of acute or long-term adverse health effects from PCB at the levels ordinarily found in humans. PCB, according to the panel, is everywhere in the national environment, and has been so recognized for at least 10 years. General exposure of the population has occurred over the past 10-30 years. The body burden in adults is therefore likely to remain about the same for several more decades. However, the Panel concluded, the next generation should experience much less PCB body burden because of the stopping of its production and improved control and disposal of existing supplies.

Members of the Panel were: Regine Aronow, MD, director, Poison Control Center, Children's Hospital of Michigan, Department of Pediatrics, Wayne State University; Mason Barr, Jr., MD, director, Teratology Unit, Department of Pediatrics, University of Michigan; Laurence Finberg, MD, Professor of Pediatrics, Albert Einstein College of Medicine, and chairman, Committee on Environmental Hazards, the American Academy of Pediatrics; Robert Miller, MD, DrPH, chief, Clinical Epidemiology Branch, National Cancer Institute; and William B. Weil, Jr., MD, Professor of Pediatrics and Human Development, College of Human Medicine, Michigan State University, and Chairman of the panel.

The following AMA Council on Scientific Affairs' statement was adopted by the AMA House of Delegates at the Interim Meeting in December 1980. It represents a clarification of the AMA's policy on "alcoholism as a disability." The Council will submit a follow-up report to the House of Delegates later this year.

Alcoholism as a disability

The AMA believes it is important for professionals and laymen alike to recognize that alcoholism is in and of itself a disabling and handicapping condition.

The AMA encourages the availability of appropriate services to persons suffering from multiple disabilities or multiple handicaps, including alcoholism.

The AMA endorses the position that printed and audio-visual materials pertaining to the subject of people suffering from both alcoholism and other disabilities include the terminology "alcoholic person with multiple disabilities" or "alcoholic person with multiple handicaps." Hopefully, this language clarification will reinforce the concept that alcoholism is in and of itself a disabling and handicapping condition.

Breast cancer screening of younger women pays off in detecting cancers early while treatment still offers hope of success, says a report in the March 13 *Journal of the American Medical Association.*

Several years ago the American Cancer Society and the National Cancer Institute funded the development of breast cancer detection demonstration projects to learn more about the effectiveness of mass screening programs. The first report from one of these projects at the University of Louisville School of Medicine — calls attention this week to the value of screening women under 50 as well as those over that age.

The Louisville group reports on a five-year screening experience for 10,128 women at the Louisville Breast Cancer Detection Demonstration Project. The screening disclosed 163 breast cancers in women aged 35 to 74 years. Thirty-four percent of those with cancer were younger than 50 years. In 69 percent of the total of cancer patients the disease had not yet begun to spread through the rest of the body at the time of diagnosis.

Of the 10,128 patients, 5,280 were between the ages of 35 and 50 years. In this group 38 cancers were detected in 37 patients through the screening program. Thus, one in each 140 younger women screened was found to have breast cancer.

Mammography was the most sensitive diagnostic method used, followed by physical examination.

In an accompanying editorial, Nathaniel I. Berlin, MD, now of Victoria, Australia, points out that earlier reluctance to use mass breast x-ray screening for cancer stemmed in part from fear of the hazards of the x-ray itself. We know more about the potential damaging effect of x-rays on breasts today, and are less apprehensive of potential damage, he says. Also, x-ray dose to the breast has been substantially reduced, to the point where potential benefits of screening now greatly outweigh the small possible risk, Dr. Berlin declares.

Gonorrhea has leveled off in the United States at around one million cases a year, and has defied the best efforts of the medical community to overcome this common sexually-transmitted disease.

A new medical approach to gonorrhea is reported in the Feb. 13 *Journal of the American Medical Association.* Colorado doctors report on an effort to find and treat men who have gonorrhea but don't know it.

Only recently has medical science become aware that perhaps as many as 60 percent of infected men also have no symptoms, and can continue to infect their partners unless treated.

Physicians now advise both men and women who have been exposed to gonorrhea through sexual contact to visit their doctor or a clinic for tests, even if no symptoms have appeared. The "Silent Clap" is a truly large-scale health problem.

A group of radiation therapists are becoming increasingly active in recommending to women with early breast cancer that they consider undergoing radiation therapy in conjunction with simple surgery to remove only the cancerous lump, rather than the entire breast.

Radiation therapy combined with surgery to remove the lump can achieve control rates that are comparable with those obtained by modified or radical mastectomy, declares Luther W. Brady, MD, chairman of the Department of Radiation Therapy and Nuclear Medicine, Hahnemann Medical College, Philadelphia.

The status of this procedure in treating early breast cancer is reviewed in the Medical News Section of the Feb. 20 *Journal of the American Medical Association.*

The acceptance of such breast-saving treatment has become even more important with the increase in detection in breast cancer at an early stage, adds Dr. Brady. He cites data showing that the proportion of women whose disease was diagnosed prior to spreading to other parts of the body increased from 72 percent to 88 percent between 1970 and 1976.

In one recent study of 293 patients, 71 percent of stage I patients and about half of stage II patients (signifying early and early intermediate stages of the cancer's growth) were alive and free of the disease ten years later. These figures compare with the 60 percent and 40 percent survival figures obtained with extensive surgery.

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/Roche) ⒸIV, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® Ⓘⓥ
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient
Contraindicated: Known hypersensitivity to the drug Children under 6 months of age Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy, gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia jaundice, periodic blood counts and liver function tests advisable during long-term therapy
Dosage: Individualize for maximum beneficial effect *Adults* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b i d to q i d alcoholism, 10 mg t i d or q i d in first 24 hours, then 5 mg t i d or q i d as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t i d or q i d , adjunctively in convulsive disorders, 2 to 10 mg b i d to q i d *Geriatric or debilitated patients* 2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (See Precautions) *Children* 1 to 2½ mg t i d or q i d initially, increasing as needed and tolerated (not for use under 6 months)
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

PHYSICIANS
ASSISTANT DIRECTOR ASSOCIATE DIRECTOR
Ann Arbor, MI

Warner-Lambert is a leading worldwide developer and marketer of health care and consumer products, including prescription and proprietary pharmaceuticals, diagnostic and hospital products, scientific instruments, confectionery and specialty foods. Our Pharmaceutical Research Division has excellent opportunities available to join the Clinical Research staff at the Assistant or Associate Director level.

These positions require:

- An M.D. degree with board certification or board eligibility in one or more of the following specialties: cardiology, oncology, anti-infectives, pulmonary diseases or internal medicine with significant experience in one of the above fields.
- 3 or more years of medical practice experience
- Background in clinical research and clinical pharmacology desirable
- Outstanding written and oral communication skills

Responsibilities include:

- Planning and implementation of clinical drug programs including protocol design and liaison with field investigators
- Preparation of reports for FDA submission
- Participation, along with preclinical research scientists, in the evaluation of new research avenues for the above therapeutic areas.

Warner-Lambert offers an attractive compensation package including competitive salary, bonus, stock option plan, malpractice coverage, and three weeks vacation. In addition, our modern research facility is located next to the University of Michigan campus in Ann Arbor, MI - an area which offers excellent recreational and cultural opportunities. Interested and qualified candidates should forward resume/curriculum vitae with salary history in confidence to: Ms. D. Love, **WARNER-LAMBERT/PARKE-DAVIS,** Pharmaceutical Research Division, 2800 Plymouth Rd., Ann Arbor, MI 48105.

An Equal Opportunity
Employer M/F/H

WARNER
LAMBERT

MEETINGS

MSMS, MSMS/A, AMA and medical assistants

May 21-23 — AMA Seminar for Physician Negotiators, Hotel Parker Meridien, New York City, contact: AMA Department of Negotiations, 535 N. Dearborn, Chicago, 60610.

June 7-11 — AMA Annual Meeting, Chicago Marriott, contact: AMA, 535 N. Dearborn, Chicago, 60610.

July 16-19 — MSMS Council, Grand Traverse Hilton, contact: Warren Tryloff, MSMS headquarters.

July 18 — 1981 AMA Seminar for Improving English Pronunciation For Foreign Medical Graduates, AMA headquarters, contact: Department of Resident Services, AMA, 535 N. Dearborn, Chicago, 60610.

Sept. 9 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Sept. 10-11 — AMA 41st Annual Congress on Occupational Health, Milwaukee, contact: Barbara S. Jansson, AMA, 535 N. Dearborn, Chicago, 60610, 312/751-6669.

Sept. 18-28 — MSMS/Intrav Italian Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

Oct. 21 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 3-4 — Diet & Exercise: Synergism in Health Maintenance, sponsored by the AMA, Walt Disney World Complex, Florida, contact: AMA Department of Foods and Nutrition, 535 N. Dearborn, Chicago, 60610.

Nov. 17-19 — 1981 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

May 19 — Michigan Week Health Day, sponsored by the Greater Michigan Foundation, Lansing, contact: Greater Michigan Foundation, 809 Center Street, Lansing, 48906, 517/487-3616.

May 23 — Membership Meeting, Michigan Psychiatric Society, Recess Club, Northville, contact: Helen Schulte, MSMS headquarters.

May 26-28 — 60th Annual Conference, Michigan Public Health Association, Sheraton Southfield Hotel, contact: MPHA, 1407 S. Harrison, Suite 340, East Lansing, 48823.

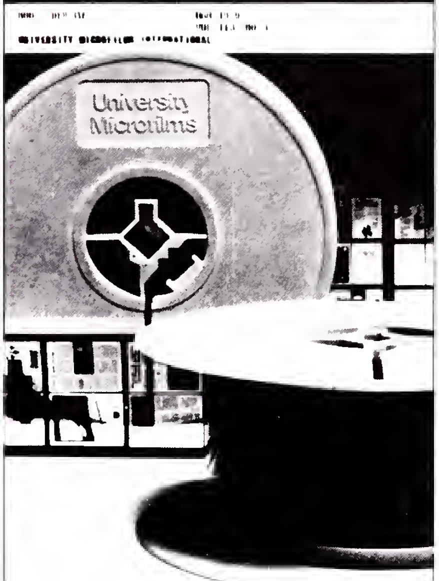
May 28 — Membership Meeting, Michigan Chapter, American Medical Writers Association, Webers Inn, Ann Arbor, contact: Ray Yeater, 5121 Hensley Dr., Ann Arbor, 48103.

June 7 — Board Meeting, State of Michigan Branch, American Association of Medical Assistants, MSMS headquarters, contact: Caroline Rich, MSMS headquarters.

June 11-12 — Annual Meeting, Michigan Occupational Medical Association, Traverse City Hilton, contact: Charles R. Buck, MD, Medical Officer, Michigan Bell Telephone Co., Detroit, 48226.

July 29-30 — 24th Annual Congress of Delegates meeting, Michigan Academy of Family Physicians, Holiday Inn, Traverse City, contact: Loretta Joyce, Executive Director, MAFP, 416 N. Homer, Suite 107, Lansing, 48912.

Aug. 28-30 — Summer Meeting, Michigan Psychiatric Society, Holiday Inn, Traverse City, contact: Helen Schulte, MSMS headquarters.


This publication is available in microform.

University Microfilms International

Please send additional information for ______

Name ______

Institution ______

Street ______

City ______

State ______ Zip ______

300 North Zeeb Road
Dept PR
Ann Arbor, Mi 48106
USA

30-32 Mortimer Street
Dept PR
London WIN 7RA
England

CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: May 14, Major Problems in Adolescence. Location: Kalamazoo Hilton. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** $55. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 East Lovell, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 14-16, Cardiac Diagnostic Techniques: A Clinical Perspective. Location: Detroit Plaza Hotel. **Sponsor:** American College of Cardiology and Wayne State University School of Medicine. **For:** All interested cardiologists. **Cost:** $190 ACC members, $235 non-members. **Contact:** Registration secretary, Extramural Programs Department, American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20014. **Approved for:** 14 hours of Category I Credit.

Date: May 16, Cytochemical Features of Leukemias. Location: Edward W. Sparrow Hospital, Lansing. **Sponsor:** Department of Pathology, Edward W. Sparrow Hospital. **For:** All interested pathologists. **Cost:** $60. **Contact:** Teresa A. McWilliams, Education Coordinator, Department of Laboratories, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., P.O. Box 30480, Lansing, 48909. 517/483-2530. **Approved for:** 5 hours of Category I Credit.

Date: May 16, Diagnostic Electron Microscopy. Location: Edward W. Sparrow Hospital, Lansing. **Sponsor:** Department of Pathology, Edward W. Sparrow Hospital. **For:** All interested pathologists. **Cost:** $60. **Contact:** Teresa A. McWilliams, Education Coordinator, Department of Laboratories, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., P.O. Box 30480, Lansing, 48909. 517/483-2530. **Approved for:** 5 hours of Category I Credit.

Date: May 16-18, Michigan Dermatological Society Central States Meeting. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Dermatological Society. **For:** All dermatologists. **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hours of Category I Credit.

Date: May 20, Family Practice Update. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** All interested physicians. **Cost:** $100. **Contact:** Ms. Linda Radu, Continuing Medical Education, 313/343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 20, Second Annual Regional Medical Conference on Infectious Disease. Location: Southwest Michigan College, Dowagiac. **Sponsor:** Lee Memorial Hospital. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Cost:** $50 for physicians. **Contact:** Judith B. Willis, Assistant Director/Regional Medical Education, SMAHEC, 252 East Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: May 22, Third Annual Associate Member Meeting. Location: Wayne State University, McGregor Conference Center. **Sponsor:** Michigan Chapter, American College of Physicians. **For:** Internists. **Contact:** Ralph Cushing, MD, FACP, Wayne State University, 313/577-5084. **Approved for:** 5 hours of Category I Credit.

Date: May 26, Recent Advances in Infectious Diseases. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Hospital. **For:** All interested physicians. **Cost:** $40. **Contact:** Butterworth Hospital Medical Education Office, 616/774-1835. **Approved for:** 8 hours of Category I Credit.

Date: May 28-30, Medicolegal Investigation of Death. Location: Detroit Plaza Hotel. **Sponsor:** Wayne State University School of Medicine, Department of Pathology and Wayne County Medical Examiner's Office. **For:** Medical examiners, coroners, forensic and other pathologists. **Contact:** Wayne State University School of Medicine, Division of CME, 4201 St. Antoine, 9B-32 DRHUHC, Detroit, 48201, 313/577-1180. **Approved for:** 15½ hours of Category I Credit.

Date: June 1-5, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing

NOT
ONLY
THE
WEALTHY
GET
TAX
SHELTERS

Take advantage of a Michigan National Bank
Tax-Sheltered Retirement Plan

Are You Self-Employed?

Set aside 15% of your income, up to $7,500 and reduce your annual taxable income by the same amount.

An Employee . . . No Pension Plan?

Set aside 15% of your income, up to $1,500 annually and reduce your taxable income by the same amount.

START YOUR TAX-SHELTERED RETIRMENT PLAN AT MICHIGAN NATIONAL BANK NOW!

Contributions can be deposited in high-yielding Certificates of Deposit. Both the deposits and the interest you earn are tax-exempt until you retire . . . AND no fees or commissions charged.

For answers to your questions about Tax-Sheltered Retirement plans,
CALL: Keith Seales — (Collect) (517) 377-3319

Michigan National Corporation Banks
Member F.D.I.C.

Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

Date: June 3-5, Current Topics in Blood Banking. Location: Towsley Center, Ann Arbor. **Sponsor:** Departments of Pathology and Postgraduate Medicine and Health Professions Education of the University of Michigan Medical School. **For:** All interested physicians. **Cost:** $130. **Contact:** Towsley Center for CME, 313/764-2287. **Approved for:** 13 hours of Category I Credit.

Date: June 4-5, Fine Needle Biopsy of the Thyroid. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital, Detroit. **For:** Pathologists, endocrinologists and cytotechnologists. **Cost:** $275. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 16½ hours of Category I Credit.

Date: June 5-8, Clinical Immunology and Allergy Conference. Location: Grand Traverse Hilton, Grand Traverse Bay. **Sponsor:** University of Michigan Department of Postgraduate Medicine and Health Professions Education. **For:** All interested physicians. **Cost:** $185. **Contact:** U-M Towsley Center for CME, 313/764-2287. **Approved for:** 12 hours of Category I Credit.

Date: June 10, Your Geriatric Patient: How Old Is Too old? Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. 313/876-1464. **Approved for:** 7 hours of Category I Credit.

Date: June 26-28, Urology Outing. Location: Grand Traverse Hilton, Traverse City. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All interested physicians. **Cost:** $150. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 DRHUHC, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: July 9-12, Eighth Annual Michigan Emergency Medicine Assembly. Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Chapter, American College of Emergency Physicians. **For:** All interested physicians. **Contact:** Catherine C. Sleicher, Executive Director, Michigan Chapter, ACEP, 1305 Abbott Road, Suite 102, East Lansing, 48823. 517/332-6500. **Approved for:** 26 hours of Category I Credit.

Date: June 15-19, Basic Principles of Manual Medicine. Location: Kellogg Center, MSU, East Lansing. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** All interested physicians. **Contact:** Sandy Kilbourn, Coordinator CME, 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 19-21, Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Benjamin Henig, MD, Keyport Clinic, 308 Michigan Ave., Grayling, 49738. **Approved for:** 12 hours of Category I Credit.

Date: June 19-21, Michigan Dermatological Society Annual Meeting. Location: Renaissance Center, Detroit. **Sponsor:** Michigan Dermatological Society. **For:** All interested dermatologists. **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hours of Category I Credit.

Date: July 26-29, 13th Annual Summer Conference. Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Opthalmological Society. **For:** All interested opthalmologists. **Contact:** Philip C. Hessburg, MD, 15401 E. Jefferson, Grosse Pte. Park, 48230. **Approved for:** 8 hours of Category I Credit.

Date: July 30-31, Coller Penberthy Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th & Madison Streets, Traverse City, 49684, 616/947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: July 31-Aug. 2, EKG Interpretation and Arrhythmia Management. Location: Shanty Creek Hilton Resort, Bellaire. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** $310. **Contact:** IMEC, 64 Inverness Drive East, Englewood, Colorado 80112. 1-800-525-8646. **Approved for:** 13 hours of Category I Credit.

Date: Aug. 18-21, Michigan Health Officers Association Annual Meeting. Location: Holiday Inn, Traverse City. **Sponsor:** Michigan Health Officers Association. **For:** All interested physicians and health officers. **Contact:** William W. Moon, MD, Box 43, Harrietta, 49638. **Approved for:** 5 hours of Category I Credit.

Date: August 29-30, Anatomy and Techniques of Regional Anesthesia. Location: Gordon H. Scott Hall, Wayne State University, Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All interested physicians. **Cost:** $175. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 DRHUHC, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 14-18, Eighth Annual Family Practice Review. Location: Gordon H. Scott Hall, Wayne State University, Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All interested family physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 DRHUHC, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 40 hours of Category I Credit.

Date: Sept. 16, Renal Disease for the Clinician. Location: Kalamazoo Hilton Inn. **Sponsor:** Michigan Nephrology Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Contact:** Charles L. Zeller, Jr., MD, Director/CME, SMAHEC, 252 E. Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, and the University of Michigan Medical Center. **For:** All interested physicians. **Contact:** Robert P. Means, Ph.D., Towsley Center for CME, University Medical Center, Ann Arbor, 48109, or phone 313/763-1423. **Approved for:** 16 hours of Category I Credit.

Date: Oct. 8-11, Regional Meeting, Michigan Chapter, American College of Physicians — Michigan Society of Internal Medicine. Location: Boyne Highlands, Harbor Springs. **Sponsor:** American College of Physicians and Michigan Society of Internal Medicine. **For:** All internists and primary care physicians **Cost:** $30. **Contact:** Boy Frame, MD, FACP, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. **Approved for:** 21 hours of Category I Credit.

Date: Oct. 11-15, 1982, Abortion: Spontaneous and Induced. Location: Maui Surf Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1011. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-15, 1982, CDS: Contraceptive Delivery Systems. Location: Maui Marriott Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1101. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-16, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

MOVING?

***Michigan Medicine* wants to know**

Please notify us a week or two in advance.

CHANGE MY MAILING ADDRESS TO:

Name ______________________________

Address ______________________________

City ______________________ **State** ________ **Zip** ________

Please paste old mailing label here:

Please send to: Peg Berry, MSMS, P.O. Box 950, East Lansing, MI 48823.

American physicians today have preeminent political action committee

By Thomas R. Berglund, MD, Kalamazoo

When it all started for the American Medical Political Action Committee 20 years ago, we were the only non-labor political action committee in existence.

Today, thanks in no small measure to AMPAC's example and success, political action committees representing every conceivable apsect of the public sector are flourishing by the hundreds. In the process, they are adding a new and exciting dimension to the nation's politics. It is a rare privilege for me to be involved with this dynamic organization and to provide you with a report on its various activities.

Leadership conference

Let me begin by reminding you that AMPAC will celebrate its 20th anniversary with some specially planned events during the fall of 1981. One of these events is a Political Education Conference on Sept. 17 and 18, in Washington, DC. All state PAC chairmen and others will be urged to attend and to share in this very educationally worthwhile experience. A gala banquet marking this birthday will be held Thursday evening, Sept. 17.

Doctor Berglund is a member of the American Medical Political Action Committee Board of Directors, is vice chairman of the MSMS Council and past chairman of MDPAC.

1980 election analysis

And now some comments about the elections just completed. For AMPAC, the 1980 elections were unprecedented in terms of successful involvement. Significant activity, in terms of contributions and independent expenditures, made this an exceptional year for our political action program. With a success rate in excess of 81 percent, AMPAC's election plan was again proven sound and well considered. During this period, AMPAC provided support to 432 candidates of which 385 ran for the US House of Representatives and 47 ran for the United States Senate. Primaries are included as well. Total dollar support to candidates, including independent expenditures and 1980 deficit contributions, amounted to $1,454,773.

For years AMPAC members have willingly contributed to political candidates with their time, their money and their amazing talents. We have also been encouraged by the ability of physicians and their spouses to be astonishingly accurate political barometers of the candidates that should be supported.

Candidate selection is vitally important, occurs at the grass-roots level, and requires a great deal of expertise. The AMPAC Board is grateful, and is encouraged, by the advice and the expertise that is contributed by its members at the Congressional District level. We are truly a participating organization, and very unique in the degree of grass-roots effort that goes into candidate selection.

Individual involvement

AMPAC is particularly appreciative of the assistance that it receives from Michigan in joint fundraising activities through the Michigan sectors political action committee. We are in this ballgame together and we can accomplish so much more in cooperation with one another.

We can help one another in other ways.

The whole thrust of AMPAC is to make medical contributions an organized force in the election process, channeling contributions where they will be the most effective. Our aim is to complement AMA activities in Washington by aiding in the election of responsible candidates, capable men and women who will at least listen to our point of view when questions regarding health care are being considered. We can only do this, and do it well, by the kind of joint participation that I have just referred to, whether it be in fundraising, candidate selection, or other ways.

AMPAC is the preeminent political action committee in America today the leader and the pace setter — and so much of the strength of our position comes from the support and participation of all the state PACs.

AMPAC responds and is responsive; it supports and is supportive; it cooperates and is cooperative with those other organizations in the federation of medicine with similar interest.

Please keep in mind that AMPAC members may have strong philosophical beliefs, but that AMPAC does not. AMPAC is neither conservative nor liberal; neither incumbent- nor challenger-oriented; neither Republican nor Democratic.

AMPAC reflects the current political activities of local physicians and their families in an election year and in the period in between. It is totally responsive to the general concensus of local physicians and their families.

Redistricting ahead

I should touch on one factor which will have such great impact on the next elections — the reapportionment that will be necessary as a result of the 1980 census. We are told the census has now been completed.

The tedious task of redrafting district lines will begin in those states that will gain or lose representation in the House of Representatives and in other circumstances as well. There continue to be shifts in the balance of power in other states even after the elections have been completed. AMPAC intends to monitor all of these situations and will be aware of any circumstances that need attention. But it is primarily an educational process. Every physician and his or her family needs to be totally aware of those factors that will be brought to play on this process and be vigilent to the necessity of a balance between the two parties to insure truly representative government.

The watch words here are: be aware; be involved. The political process for the next 10 years will be decided in the next few months in your state legislature.

What we do in the next few weeks and months is absolutely vital to all that we as physicians believe in and ascribe to in our daily lives, and in our practice of medicine. I urge each of you to make political activity a year-round priority. Just because an election was held last month does not mean that we can sit back and wait until the September of the next election year before we begin our political activitiy. Democracy requires a continuing commitment to find better candidates to run for public office. Once found and recruited, they need exposure to potential voters and strong support by AMPAC and MDPAC. They must be honest, they at least must be willing to listen to medicine's views on the issues, and they must have local physician support.

The system works, and it will continue to work if we care enough to make sure that it does. There is no doubt in my mind whatsoever that the men and women of medicine, and their families, committed to a strong America, will respond to the challenges as they have always done: with strength and resolve, and with a sense of responsibility.

Administrative office and main laboratory

AMRC the full service laboratory

- **Complete range of individual tests and diagnostic profiles**
- **Medical consultation services**
- **Comprehensive quality control program**
- **Fully accredited**
- **Complete billing service**

ADVANCE MEDICAL & RESEARCH CENTER, INC.

1270 Doris Rd. • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

Congress, in next two years, to rethink medicine's entire base

By Theodore N. Cooper, MD, Kalamazoo

The following article is excerpted, with permission, from an address delivered by Doctor Cooper to the 1981 AMA Leadership Conference. Doctor Cooper, now executive vice president of the Upjohn Company, Kalamazoo, left New York City in Sept. 1980 for his new position, after serving since 1977 as dean of the Cornell University Medical College. Prior to that, he was Assistant Secretary for Health of the Department of Health, Education and Welfare.

We are on the threshold of a new era in the medical profession, as we are entering a major change in American life. We will be trying to reconstruct American self-confidence, and we shall be re-examining our values and our institutions.

The public is still of a mind that it ought to have the *best* in medical care, however. We as a nation will have to face the facts of what having the best means in practical terms. And we will have to decide if we mean it.

It is imperative that those who will fashion, vote on and implement programs understand the limits of and requirements for medical services. Physicians must provide authoritative views — credible views — on these points.

The physician has a tremendous amount to offer in solving the problems of society. A physician, by definition, is more than a technical expert. Technicians are resources for policy formulation and planning.

Health greatest asset

Physicians should be leaders of social thought. Society has problems. Society's greatest asset is the health of its people. Physicians have a part of the stewardship of that asset. It would be a tragic loss to the problem-solving capacity of society for us to be excluded or to withdraw out of annoyance, or frustration, or a sense of futility.

Most of the time, effective participation is achieved only after increasingly demanding preparation.

Such is the role and value of our organizations.

Participation by organizations is often characterized as "vested interest" or a lobby. There is nothing wrong with having an interest or reflecting a special interest. There is nothing wrong with lobbying. You can do it inappropriately or badly.

But you can also lobby in the right way — honorably and well. To be effective you must be timely. Organizations can help make participation timely by staying abreast of the activities in Washington or in state capitals.

There is a growing interest in the national capitol in prevention and in various forms of health education and health promotion. Secretary Schweiker has put it at the top of his list. The Congress has passed a law to give the area visibility. Surgeon General Julius Richmond has pointed out the opportunities repeatedly.

While I enthusiastically support these noble objectives (and I have the scars to prove it), I believe that national policy must recognize the limitations of the approach. For example, how results will be measured is not clear. The public is used to thinking in short time frames. I worry about an *expectation* of a policy that is only *an expressed commitment to one approach*, only one part of a larger problem.

Whether the expectation is in reduction of cost or in improvement of the human condition, we must understand that prevention will not, by itself, accomplish our aims — certainly not within this century, certainly not without much more new information derived from research, and certainly not without spending dollars.

We should not lose sight of the reality that millions of people will need acute care for the foreseeable future. Prevention and acute care are compatible concepts, not *alternatives*. Obvious you say. *Don't believe it.*

Next two years

I take this frame of reference because many old authorities will be discussed in Congress in the next two years. Virtually the entire base of the medical enterprise will be discussed in one way or another.

We will be asked again to change our priorities in research and in the way we manage research. We will be asked to change the medical curriculum and the applicant selection process. We will be asked to compete for patients rather than just to serve them. We will be asked to prove that we know what we are doing.

Such questions should not be viewed as *threats*. They should be viewed as providing opportunities to help fashion the future of the system on a sound professional, scientific, and socially sensitive base.

Too many people equate respectability with noninvolvement. Too many people place protecting tax-exempt status above the protecting integrity of the system.

It is time for a recommitment of American medicine to a leadership role in the formulation of national health policy.

The profession has slipped into a defensive posture. We must think and lead. We owe it to our patients.

Doctor Cooper is executive vice president of the Upjohn Company, Kalamazoo.

Acute pain is no laughing matter.

The first prescription for the first days of acute pain

Empirin® c̄ Codeine #3

Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming).

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin c̄ Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin c̄ Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with . . . two tablets of Empirin c̄ Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No 2 — 15 mg, No 3 — 30 mg, and No. 4 — 60 mg (Warning — may be habit-forming.)

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

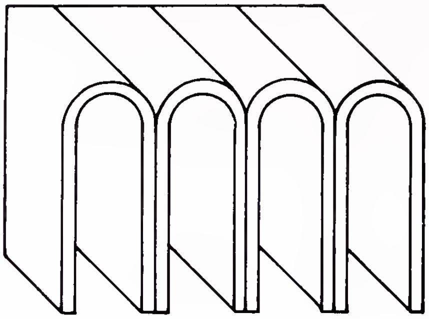
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

DEATHS



Joseph V. Baublis, MD
Ann Arbor

Joseph V. Baublis, MD, Ann Arbor, died Mar. 7 at the age of 50. Doctor Baublis was a professor of pediatrics and communicable diseases at the University of Michigan Medical School. One of his major research interests was in Reye's Syndrome. With U-M neurosurgeons, Doctor Baublis had helped devise a new way to monitor the intracranial pressures of Reye's Syndrome patients and thereby prevent death or brain damage due to the disease. He received his medical degree from McGill Medical School in Montreal in 1956. He was medical advisor to the National Reye's Syndrome Foundation and a member of the Reye's Syndrome Task Force of the Michigan Department of Public Health.

Keith F. Bennett, MD
Kalamazoo

Keith F. Bennett, MD, Kalamazoo, died Feb. 22. He was 72. Doctor Bennett earned his medical degree from the University of Michigan Medical School in 1935. He maintained a private practice in Kalamazoo for 45 years. He was on the staff of both Bronson Methodist Hospital and Borgess Medical Center. He served as former medical director of the Kalamazoo County Medical Catastrophe Committee. He was a fellow of the American Occupational Medical Society and the Michigan Occupational Medical Society.

Frederick F. Birkam, MD
Big Rapids

Frederick F. Birkam, MD, Big Rapids, died Feb. 18 at the age of 58. Doctor Birkam was chief of medical services at the Ferris State College Health Center. He received his medical degree from Wayne State University School of Medicine in 1947. He was affiliated at one time with Mt. Carmel Mercy and Oakwood hospitals.

Jesse L. Leach, MD
Flint

Jesse L. Leach, MD, Flint, died Feb. 26. He was 85. Doctor Leach was president of the state NAACP from 1941-51 and was given a special award by the Michigan State Conference of NAACP branches in 1968. In 1966, he became the first black president of the Michigan Academy of General Practice. He earned his MD from Meharry Medical School in 1914. Doctor Leach was the first black named to the old Genesee County Board of Supervisors and served more than 20 years before resigning in 1949. He also served as county medical examiner and was a member of the old Genesee County Board of Health.

Richard O. Sacks, MD
Huntington Woods

Richard O. Sacks, MD, Huntington Woods, died Feb. 26 at the age of 36. Doctor Sacks received his MD from the Wayne State University School of Medicine. He was a member of the Michigan Gastroenterology Society and the Detroit Institute of Arts Founders Society.

Junius L. Taylor, Jr., MD
Detroit

Junius L. Taylor, Jr., MD, Detroit, died Feb. 15. He was 68. Doctor Taylor earned his MD from the Meharry Medical College in Nashville in 1939. He was the first black American physician employed by the Veterans Administration. He served as chief psychiatrist with the forensic center for Detroit Recorder's Court. He was also a member of the American Psychiatric Association and the NAACP.

Maurice E. Willis, MD
West Bloomfield

Maurice E. Willis, MD, West Bloomfield, died Mar. 2. He was 60. Doctor Willis practiced psychiatry in Pontiac for 30 years and was on the staff at Pontiac General Hospital for 25 years. He served as chief of psychiatry at Pontiac General for five years. He earned his MD from Wayne State University School of Medicine in 1945. He was a diplomate of the American Board of Psychiatry and a member of the American Psychiatry Association.

DOCTOR YLVISAKER/*continued*

called into account. In essence, the Society is challenged to change policy or work aggressively to change the system.

New mechanisms have been instituted or advanced to achieve *more effective representation, function, outreach, and influence.* Among these are: a new mechanism for specialty society leadership to interact directly with The Council; a new mechanism for the society to interact with hospital medical staffs through their presidents; a proposal worked out with medical faculty representatives for a strong, functional interlocking of faculty and society concerns; a new, more objective mechanism for interacting with the Board of Medicine; a comprehensive "network" program for the impaired physician; a formal leadership liaison with the Michigan Hospital Association; a proposed change in the structure of society relationships with third party reimbursers.

Lastly, and potentially most important, the groundwork has been laid for an equal partnership of the society in a coalition of the major forces having responsibility or a vested interest in health care in Michigan. This coalition includes labor, industry, insurers, and providers. It could easily assume a major role in the formulation of public policy for health care.

I have deeply appreciated the honor and privilege of serving all of the members of the Michigan State Medical Society as their president. I pass the responsibility of this leadership to Doctor Fryfogle with my every best wish and full support.

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

Many physicians will not have disability income protection to replace their loss of income...Most physicians will not have professional overhead coverage to pay their ongoing office expenses.

Will you be one of these physicians..."It won't happen to me."

Your MSMS group plans can provide this needed protection. For more information about rates and applications call toll free, 800-292-1966.

"we're here to help"

Stratton-Cheeseman & Associates, Inc.
1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823

*1979, The National Underwriter Company

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

PRACTICE OPPORTUNITY: Staff position of general surgeon available at Health Central, staff-model HMO, subsidiary of Blue Cross Blue Shield of Michigan. Please send salary requirements and CV to: Gertrude Sadoff, Health Central, 2316 S. Cedar, Lansing, 48910.

CLINICAL RESEARCH PHYSICIAN. The Upjohn Company's Experimental Medical Research area has an opening for a physician to participate in the conception, design, implementation, execution and analysis of G-I investigational drug development as part of the Digestive System Research Sub-program. Present lines of investigation include G-I antisecretory disease states, intestinal motility and cytoprotection. Qualifications include an MD, and the equivalent of an internship. Clinical practice and medical licensure desirable; pharmaceutical industry drug development experience and board eligibility preferred. The position, together with excellent salary, benefits, regularity of hours and an opportunity to work at the forefront of medical research, offers an attractive and meaningful alternative to hospital and private practice. Send resume in confidence to: Kathleen diCicco — 9231, The Upjohn Company, 7000 Portage Road, Kalamazoo, MI 49001. An Equal Opportunity Employer M/F.

RADIO-THERAPIST — Prominent 73-man multi-specialty clinic offers salary with excellent fringes including income distribution plan, optional stockholding, medical, life and malpractice insurance. Ultra modern clinic, fully equipped with Varin Clinac 6X Linear Accelerator, attached to hospital which serves as a major referral center. Position located in popular resort area in the lower peninsula on Lake Michigan. Call Durham Medical Search (collect) (716) 852-5911, Suite 600-P, 268 Main Street, Buffalo, NY 14202.

GENERAL SURGERY PRACTICE FOR SALE — Monroe, Michigan due to moving. Office immediately available. Selling for one-half of gross. Patient charts for 26 years. For information, call 313-241-7600 or write to R. W. Wilkins, MD, 118 Cole Rd., Monroe, Michigan 48161.

PHYSICIAN: FERRIS STATE COLLEGE is seeking two additional physicians to complete the staff of the Student Health Center. Attractive salary, fringe benefits, pleasant location, excellent facilities and working conditions. Please contact Wesley F. McGinnis, DO, (616) 796-0461, ext. 5270, or write c/o Ferris State College, Big Rapids, MI 49307. Ferris State College is an Equal Opportunity/Affirmative Action Employer.

NEED FULL TIME OR PART TIME PHYSICIAN OR P.A. in a busy general practice in semirural set-up close to Ann Arbor. Some industrial and insurance physicals. Very interesting and varied. Salary negotiable and commensurate with experience. Please call 313-697-9300 or send resume to Belleville Medical Clinic, 265 Main Street, Belleville, MI 48111.

PEDIATRICIAN: Board eligible or certified with sub-specialty or experience in neonatology or diseases of allergy wanted as associate in private practice in mid-Michigan location, population 60,000. Four year contract. Salary $40,000 1st year, $45,000 2nd year, $50,000 3rd year and $60,000 4th year. Additional malpractice insurance, hospitalization insurance and medical association fees paid. Three weeks vacation. Immediate opening. Call 517/892-2517.

PHYSICIAN NEEDED for Jackson Medical Center, Inc., a non-profit clinic providing medical care for patients in need, regardless of ability to pay. A permanent position with very attractive salary (approximately $50,000.00), 30-40 hour work week, no weekends, no nights, no hospital duty. Prefer family physician. Contact: E. Willoughby, MD, 569 Wildwood Ave., Jackson, MI 49201.

PHYSICIANS NEEDED IN ROGERS CITY AND POSEN, MICHIGAN. Excellent opportunity for physicians seeking a wide variety of financially rewarding professional experiences. Located near Lake Huron with excellent outdoor and family lifestyle. Attractive income guarantee in solo or group practice settings. If interested call collect to: Evans Calas, Assistant Administrator, Rogers City Hospital, (517) 734-2151.

PRIMARY CARE PHYSICIAN NEEDED to join staff at growing practice in scenic central Virginia, near Lynchburg. Enjoy well-equipped facility, excellent staff, strong community support, guaranteed income, excellent linkages with hospitals and other providers in area with beautiful mountains, large lakes, and year-round mild weather. Strong local economy. Unemployment rate only 4.6% and population is growing! Contact: John Troidl, Administrator, Evington Medical Center, Evington, Virginia 24550. (804) 821-3136.

MISSOURI OB/GYN, group opportunity with four family practitioners. Offices adjacent to hospital. Excellent family area, with relaxed life style in small town, near several large cities. Attractive financial arrangements. Send replies in confidence to Box 13, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

KENTUCKY TOWN NEEDS GP — friendly town in eastern Kentucky, has hospital in adjacent city with complete services and specialists. The hospital and community will provide a complete financial package to insure a successful practice. All replies kept confidential. Contact Administrator, Box 12, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

PARTNER NEEDED — by Arkansas GPs — two established physicians with office near hospital need third physician GP or internist for busy practice located in the beautiful Bull Shoals area. Attractive financial arrangements. Send replies in confidence to Box 11, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

MEDICAL ONCOLOGY FELLOWSHIP. Currently available for 1 or 2 years at the Edward W. Sparrow Hospital, Lansing, Michigan. Emphasis on clinical training with research opportunities, including work in interferon trials. Prefer applicant who has completed 2 years of internal medical training. Send curriculum vitae to: Francis A. Breen, Jr., MD, Director of Medical Oncology, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, Michigan 48909. A Non-Discriminatory Affirmative Action Employer.

FAMILY PHYSICIAN TO JOIN two Board Certified family physicians and one physician's assistant in a young and growing medical practice in central Minnesota. The practice is oriented toward family medicine. The practice is located centrally in the state with quick access to Minneapolis/St. Paul. Cultural and recreational activities are in abundance in this area of Minnesota. Salary open: Contact Dary G. Mathews, Adm., or Thomas J. Newton, MD at the Cold Spring Medical Clinic, 26 N. Red River Ave., Cold Spring, MN 56320. Call 612-685-8641.

OBSTETRICS AND GYNECOLOGY — Grad Year II — Unexpected opening July 1, 1981 in fully accredited 4 year program in large community teaching hospital. For information cal or write Dept. of Health Educ., St. John Hospital, 22101 Moross Rd., Detroit, MI 48236. 313-343-3875.

FORT WAYNE, INDIANA — EMERGENCY DEPARTMENT PHYSICIANS. American Medica Services Association, Inc., a Kansas City based multiple hospital physician group, is seeking career oriented primary care and emergency care physicians who are: board eligible or certified, show an affinity for the team concept o medical practice, business oriented, show professional maturity and judgment, have a keen desire to succeed, committed to CME. We are successful because we offer the unique package of salary and benefits in the health care industry. All of our physicians participate in the ownership of the company. If you feel qualified, we are interested in you. Contact Michael P. Colucci, Vice-President of Marketing and Recruitment, American Medical Services Association, Inc., 4400 Broadway — Suite 306, Kansas City, Missouri 64111. 816-931-3040.

ONCOLOGY FELLOWSHIP — 1 or 2 year program in 550 bed teaching community hospital with fully approved residency programs in internal medicine, general surgery, ob/gyn, pediatrics and pathology. Requirements: Completion of 3 year internal medicine residency. For information contact Dept. of Health Educ., St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

NEPHROLOGY FELLOWSHIP — 1 or 2 year program in 550 bed teaching community hospital with fully approved residency programs in internal medicine, pediatrics and general surgery and 16 station out-patient esrd. Requirements: Completion of 3 year internal medicine residency. For information contact Dept. of Health Educ., St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

NEUROSURGERY FELLOWSHIP — 1 year program in 550 bed teaching community hospital, a designated trauma center, with fully approved 5 year general surgery residency. Requirements: Completion of neurosurgery residency. For information contact Dept. of Health Education, St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

CALIFORNIA-DIRECTOR POSITIONS AVAILABLE. Emergency medicine physicians needed for rural Northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit-sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610. 415/832-6400.

OB/GYN PARTNERSHIP — Young ob/gyn located in Southern Illinois, with an expanding practice, needs a partner. This pleasant community is family oriented, with good schools and a new hospital. All replies will be kept confidential, send to Box 14, MSMS, 120 W. Saginaw St., East Lansing, MI 48823.

GENERAL PRACTICE FOR SALE — Flint, Michigan, due to retirement. Office for one or two doctors available immediately. Grossing in 6 figures. No ob. No medicaid. Replies to Box 15, MSMS, 120 W. Saginaw, East Lansing, MI 48823.

PEDIATRIC RESIDENCY — Grad Year II — Unexpected opening for July 1, 1981 in fully approved three year program in large community teaching hospital. Write or call, Dept. of Health Educ., St. John Hospital, 22101 Moross, Detroit, MI 48236. 313/343-3875.

LOCUM TENENS — Pediatrician wanted to cover practice in a beautiful resort area, beginning July 12 til August 12, 1981 for two weeks or the entire period. Compensation negotiable. Please contact: Nora F. Chang, MD, FAAP, 828 Oak St., Cadillac, MI 49601. Phone: 616/775-4696.

Ear, Nose and Throat practice available. Established for the last 40 years. Located in Southfield, Michigan, in medical building adjacent to hospital in prime medical/commercial area. Excellent opportunity for new practitioner, or for established surgeon to expand own practice. For information call (313) 569-6569.

OB-GYN: Board eligible or certified to join busy practice in a beautiful resort area close to Detroit. Excellent office located one mile from hospital. No investment required. Equal work. Salary open. Partnership available after first of year. M. I. Sabbagh, MD, P.O. Box 163, St. Clair, 48079. 313/329-7000.

PART-TIME PHYSICIAN needed to do routine physicals to assess donor suitability for plasmapheresis. Good position for older physician looking to slow down. Malpractice coverage provided. Contact Thomas Anderson at American Plasma Management, Kalamazoo, MI. Phone 616/381-0086.

LOCUM TENENS WORK WANTED. The more you know about choices, the easier it is to choose. That's why CompHealth, the oldest, largest locum tenens organization in the United States, can help make choices easier for you. Any specialty can be covered including: FP, IM, Rad., Anes., and Ob/Gyn. With a large selection of reliable qualified physicians to choose from, CompHealth provides physicians, hospitals, clinics and communities with dependable locum tenens coverage, allowing you to keep your practice covered without inconvenience or concern. Turn a difficult decision into an easy choice. Contact CompHealth, 175 West 200 South, Suite 2003, Salt Lake City, UT 84101. 801/532-1200.

Positions With The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Miscellaneous

FOR SALE OR EXCHANGE — BY OWNER. Beautiful, almost-new summer home on approximately 12 acres on private lake with 400′ frontage. No motor boats allowed. Nearly 2 miles back in the woods, between Bitely and Baldwin, Michigan, adjacent to the 60,000-acre Manistee National Forest. 4 bedrooms, 3 baths, arge rec room, large living room-dining room-kitchen combination. Laundry room with washer and dryer. Compactor, central vacuum system, public address and radio throughout. Air conditioning, gas furnace, deep well. 2 arge fireplaces with heat-a-lators. Anderson Thermo-Pane windows. Wood paneling, carpeted, furnishings, including boats. All that and purple martins, too! Seller will finance at 12%. Price $149,500. Phone 616-361-8439.

LUXURY CHALET FOR SALE, beautifully furnished, 5 large bedrooms, 3 full baths, in all-season northern Michigan resort. Golf, tennis, skiing, water sports, hunting, fishing, near excellent airport. Ideal for two-family or corporate ownership, too. Owner, (616) 587-9241 after May 25.

DOCTORS-PHARMACISTS-OFFICE & RETAIL SPACE AVAILABLE. Will build to suit. Corner of Gratiot & 27 Mile Rd. Just minutes from St. Joseph & Mt. Clemens General Hospital. Call Ron . . . 749-9595.

LAMINAGRAPHY SYSTEM — Approximately 15 years old. G.E. 300 ma, 125 KVP, Phillips table. Excellent condition, $9,800. Doctor S. G. Hastings, Box 335, Dexter, MI 48130. (313) 426-4632.

SANDRA W. COCHRAN, MEDICAL ILLUSTRATOR. Medical illustration available, from detailed realistic renderings to simple diagrams, graphic design and biophotography. For quality illustrations at the lowest cost, call (313) 652-2547, or write 1163 Ironwood Court, Apt. 104, Rochester, Michigan 48063.

2500 SQUARE FOOT BUILDING WITH X-RAY ROOM BUILT IN. Several examining rooms. Lots of parking. Sanitary sewers, air conditioned, nicely landscaped. Owner will finance with reasonable down payment and terms. Call Frank Richardson at Partridge Real Estate, in Pontiac, at (313) 481-2111.

OFFICE PLANNING & DESIGN of the spaces and the systems which allow a medical practice to thrive. PSCrawford Associates offers professional assistance in developing programs for work flow and space utility which incorporate efficient, humanistic design ambiance. Our services are structured to take your project from initial planning through completed installation. For a free Facilities Planning Checklist to aid you in defining your design needs call Pam Crawford at 313/665-5742 or write PSCrawford Associates, 116 E. Liberty, Ann Arbor, 48104.

REAL ESTATE DEVELOPMENT AND ZONING. Prior to purchasing investment property, you should be aware of how much floor space the site can support, zoning restrictions and the market feasibility of the intended use. Villican-Leman & Associates, Inc., Community Planning Consultants, are experts in planning and zoning analysis, market feasibility studies, mortgage submission packages, site planning, landscape design, and more. Call or write for prospectus or further information: 29621 Northwestern Highway, Southfield, Michigan 48034. 313/356-8181.

St. Clair Michigan — Modern medical office, near hospital, 1200 sq. ft., available January 1981. Good growth location and pleasant living. Ample parking. Reasonable rent. Call M. I. Sabbagh, MD, 1-313-329-7000.

Howell, Michigan — 8,000 sq. ft., medical-dental, available January, 1981, in attractively designed professional building. Complex conveniently located within walking distance of hospital which serves fastest growing county in state. For information, call evenings, 517/546-8895.

OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

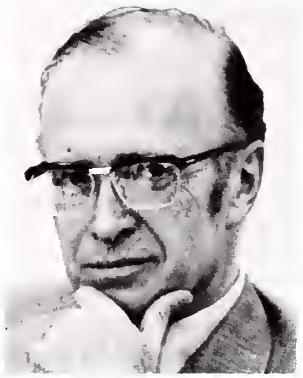
Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury, two & three bedroom units. Near Boyne ski hills. $92,000-$96,500. Furnished unit rentals available for vacation year round. A.K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

Hilton Head Island, SC. Ocean Villa, Captain's Cove in Palmetto Dunes Resort. Luxurious new villa, 150 yds. from beach. Lagoon backyard, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, pool, fishing, canoeing, biking, etc. Weekly, monthly. Call or write, 313/695-0356, 6236 Kings Crown Rd., Grand Blanc, MI 48439.

WE HAVE VARIOUS QUANTITIES OF MEDICAL EQUIPMENT available in excellent condition. We buy, sell, trade, move. New equipment also available. Call Doctor Medical Resale, 313/569-4407, 9 a.m. to 9 p.m.

Thanks to our advertisers

Ad Council	252
Advance Medical Research Center	261
American Red Cross	230
Brown Pharmaceutical	219
Burroughs Wellcome	214, 263
Campbell Labs	242
Carlton Numismatics	240
CBC Labs	245
Detroit Bank & Trust	237
Emergency Consultants, Inc.	240
I. C. System	225
Eli Lilly	221
Marion Labs	235
Marshfield Clinic	226
Medical Protective	228
Merrell-National, Inc.	232, 233
Michigan Bell Telephone Co.	239
Michigan National Bank	258
Michigan Physicians Mutual Liability Co.	223
Music Hall Center for the Performing Arts	226
ParaData of Michigan	241
Physicians Insurance Company of Michigan	243
Roche	212, 213, 214, 230, 231, 255, 256, IBC, BC
Sequoia Group, Inc.	229
Smith, Kline & French	249
Stratton Cheeseman	265
University Microfilms	257
Upjohn Co.	250, 251, 252
Warner-Lambert/Parke Davis	256



PRESIDENT'S PAGE

Reflections on a year as MSMS president

By John R. Ylvisaker, MD, MSMS President

This will be my last president's page — and my last opportunity to exercise the prerogative of telling you "how it is." I won't pull any punches. I'll deal with two areas:

1. What do I think of the job.
2. What did I do.

The job

The presidency truly is a leadership position, but it is not structured as such. The sequency of accession, though by election, too frequently is viewed as a career "reward" and too easily becomes honorary, titular, and thus perfunctory. The leadership responsibility is overlooked in the functional patterns of the society. Thus the actual exercise of leadership becomes an expression of the commitment, time and personal drive of the individual.

Frankly, I found that I had to create my own agenda for leadership and my own personal technique for surfacing issues and pursuing objectives I felt essential for the advancement of the society and the profession.

Fortunately, I had an excellent, cooperative, supportive coleader in Doctor Louis Zako, chairman of The Council. Also, The Council was very supportive (tolerant?), although possibly not all members were always fully aware of the significance of some of the initiatives approved.

There is a fantastic amount of work which requires doing. Physician perspective is a constant need. The time is too little and too short for a president to "move the mountains." So the society must choose its president carefully. Election should not be a reward, but rather the result of competition by mature but aggressive leaders.

Accomplishment

Those who dedicate themselves to a cause do so in the hope of leaving the world a little better than it was found. The legacy of leadership becomes the inescapable heritage of those who follow. The perception of what constitutes that "legacy" may be clouded by first person observation but possibly benefited by more intimate awareness.

My involvement with organized medicine has grown out of the conviction that those privileged to serve this great profession share the responsibility of sustaining its essential attributes: *humanitarianism* and *professionalism*. Effective discharge of this responsibility can only be achieved by the collective effort and dedication of members of the profession organized with a common purpose.

Previously, the "legacy" of my years as treasurer was the asset management program, supported by loyal dues-paying members, which produced a financial strength that has made possible the support of an excellent staff and essential activities, the establishment of our mutual liability insurance company, the Stockwell building, the impaired physician assistance fund, and has set the stage for many creative initiatives.

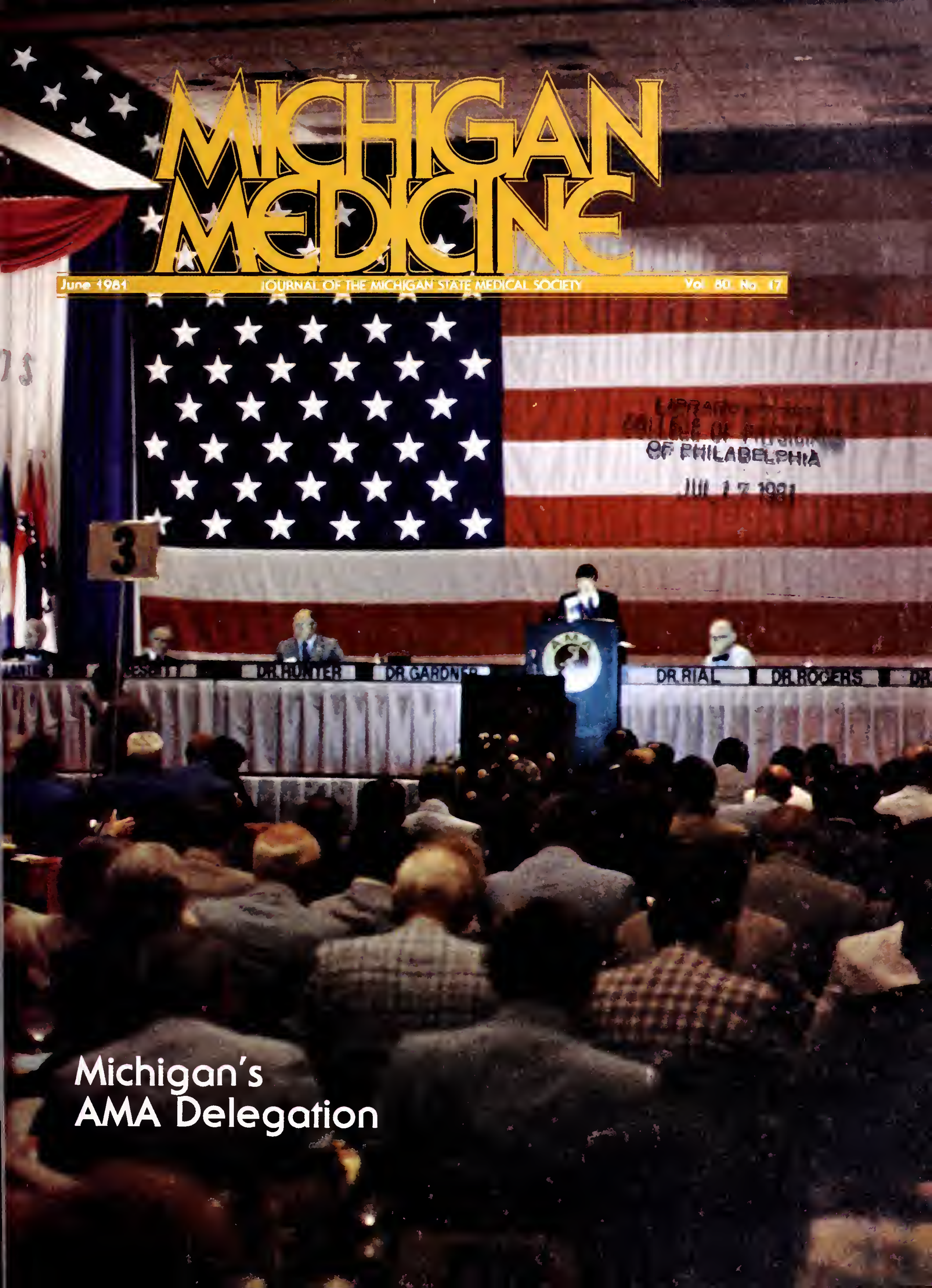
Activities of my past year as president are of less measurable impact. Only time will tell. The routine of officiating, speechmaking, and fulfilling society expectations falls on each president in greater or lesser degree. To me, the potential "legacy" will evolve out of how the society builds on initiatives or structural changes for which I was primarily responsible or where I concentrated my efforts. Of these, I count the following as most important:

A comprehensive *long range plan*, the first of many years, has been submitted to the House of Delegates. It is built around those same two essential elements of our professional lives; *humanitarianism* and *professionalism*. All of what must or should be done by the society is viewed in the context of these elements. The plan addresses traditional and current issues as these are recognized by some of our best minds. It is a roadmap which I hope the society will follow carefully and place in the hands of every member.

Reimbursement

A frank and detailed *exposition of the issue of reimbursement* of medical services has been developed. This may not be scholarly from the standpoint of the academician, economist, unionist, actuarial, or politician, but it is a candid analysis from a physician perspective of how and why present methods of reimbursement are the basic cause of cost excesses, of a warping of patterns of medical practice and care, and of an erosion of the fundamental mutual responsibilities of patients and providers. Society policy is reviewed and the conflict of policy with current reimbursement practice is

continued on page 264


3
DR.HUNTER
DR.GARDNER
DR.RIAL
DR.ROGERS

MICHIGAN MEDICINE

June 1981 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 80, No. 17

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JUL 17 1981

Michigan's AMA Delegation

Who to call at MSMS headquarters

Advertising (in *Michigan Medicine*)	Judy Marr
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Facilities	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Marce Ireland
Category I Calendar (for *Michigan Medicine*)	Bonnie Groff
MSMS-Sponsored Conferences	Sherry Fent
Cost Containment Programs	Debbie Zannoth
Dues Payments	Jerry Trahan
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	John Richards
Health Planning	Dennis Paradis
Impaired Physicians	Marcelyn Ireland
Jail Health Project	Dick Campau
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
Medical Assistants	Caroline Rich
Medical Auxiliary	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Judy Marr
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Vi Heins
Michigan Doctors Political Action Committee	Kevin Kelly
Michigan Medicine (MSMS Journal)	Judy Marr
Michigan Psychiatric Society	Helen Schulte
Michigan Society of Anesthesiologists	Caroline Rich
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Facilities	Marce Ireland
MSMS News Relations	Mert Scholten
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
Physician Hospital Relations	Bill Madigan
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	Bill Madigan
PSRO	Sherry Wellman
Specialty Societies	
Information	Nancy Wimmer
Council of Specialty Societies	Bill Madigan
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society
120 West Saginaw (Box 950)
East Lansing, MI 48823

MSMS PHONE: 517/337-1351

Opening ceremonies at an AMA House of Delegates Annual Meeting are the scene of our special report this month, beginning on page 278. Photo courtesy of the AMA.

MICHIGAN MEDICINE

June 1981, Volume 80, Number 17

Special report

278 Spotlight on the Michigan delegation to the AMA, with a description of how the delegation operates, its plans for the 1981 meeting, photos and biographies of delegates, and a discussion of the AMA's significance and contributions; Richard J. McMurray, MD, and John J. Coury, Jr., MD

Features

270 MSMS Program to Assist Impaired Physicians growing; Stephen C. Mason, MD

272 Photo highlights of the 1981 MSMS House of Delegates; Rod Rieser and Mert Scholten

290 The details behind the 30 percent rise in MSMS group health premiums; Donald G. Blain, MD

292 Report on the 1981 MSMS Sports Medicine Conference; Kim Dean

294 National Center for Health Services Research reports: physician office charges and average appointment waits; Martha Climo

296 Michigan medical students on the job this summer; Michael Vella

304 Computers: Tools for cost-effective management; Jeffrey Rich

306 Profile of Rep. Jean Willoughby; Willah Weddon

319 Ingham County nearly halves its gonorrhea rate; J. Maxwell Cook, MD

322 The medical management of obesity; David E. Schteingart, MD

326 Same-day appointment plan; Elmer White

Departments

271 Letters

284 MSMS/A; Barbara Grennan

299 New members

302 Views; Douglas A. Sargent, MD

308 News; Bonnie L. Groff

310 Medico-legal; A. Stewart Kerr

314 Medical newsfronts

328 Category I courses

330 Meetings

331 Deaths

332 Classified ads

333 Ad index

334 President's page; James D. Fryfogle, MD

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JUL 17 1981

IN MY OPINION

MSMS working toward potential of its Impaired Physician Program

By Stephen C. Mason, MD, Ann Arbor

The MSMS Program to Assist the Impaired Physician has been making impressive strides in its effort to create a decentralized program.

All the larger county societies (with one exception) have initiated the process of setting up Health and Well-Being Committees, which are the most essential component of the present system. Although these committees are not all fully functional, they are working toward that goal and they represent a triumph over the inertia and apathy of the past. They indicate that medicine is seriously undertaking responsibility for the impairment problem.

As of this writing, over 90 percent of MSMS members are covered by these committees. The remaining 10 percent are members of smaller county societies that either see no need for a committee or have not yet found a way to regionalize and consolidate their membership with neighboring societies into an effective force to help faltering physicians. For these societies, the MSMS Sub-committee on Intervention and Treatment is available. But it has its limits. A preferable system is one that is closer to the problem, to the sources of information and to the people involved, so that early case finding and prompt action can take place.

Doctor Mason is a psychiatrist and member of the MSMS Impaired Physician Program.

To paraphrase William Shakespeare, "Sweet are the uses of advocacy." This is becoming evident, as the beneficial influences of health and well-being committees become apparent.

To cite an example that has come to my attention, a particular physician had been in distress and struggling alone with his problem for years. It was only with the first call from his health and well-being committee that his sense of isolation and dispair began to break down. As he later met with the intervention team from this committee, he began opening up and sharing the problem that he had felt so compelled to cover up. His "covering up" also had led to his self-treatment of a serious medical problem because of fear that disclosure would adversely affect the course of his medical career.

The sudden awareness that he had colleagues who were concerned and wanted to help him, was like the appearance of the morning sun from behind heavy clouds. It dramatically started things moving in a different direction. As things have developed, this doctor is now a very different person, and a much more effective doctor.

Advocacy is a caring and sharing and a concern. In actual practice, it is most effective when it is "tough love" — a concern that faces the harsh realities that living and growing inevitably present.

This is our health and well-being system working at its full potential.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
John R. Ylvisaker, MD, Pontiac

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $20.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. ©1981 Michigan State Medical Society.

LETTERS

A privilege

This letter responds to a recent *Medigram* request: How to keep patients happy?

In 40 years of a very active medical practice I never had even a threat of a malpractice suit. I feel that certain ideas I used were responsible for the development of such a relationship as to assure freedom from antagonistic feeling, the inevitable prelude to serious problems:

I never thought of "patients" under my care as being other than "friends." We never had a tug of war, but worked together on the problem. I smiled at them, and made certain that they fully understood what we were trying to accomplish.

I tried, even under trying circumstances, to convey a feeling of optimism. I never told them that their condition was hopeless, but never lied. I never played God. Even when the percentages were not favorable, I concentrated on trying to build their morale and will to fight.

I encouraged them to return or call me if need be. I was always available on the phone, even during office hours.

I tried to make them feel that they got their money's worth. Even if they were wrong, if they wanted, I adjusted the fee. I gained stature, and it didn't make too much difference on the bottom line.

Visibly, I kept my cool, even if they were upset, nervous or apprehensive.

Even when I didn't like them, I tried to remember that it was a privilege to take care of them — a life which they valued highly — the only one they would ever have.

William G. Birch, Sr., MD, LLD
Largo, FL

President's page

I read with interest Doctor John R. Ylvisaker's "President's Page" in the April *Michigan Medicine*.

In the article, he stated that "health planning (is) — costly, highly politicized, and judged by repeated studies to be ineffective, time-consuming, and often disruptive." I would like to point out the following:

Health planning cost $6.2 million in Michigan in FY 81. This amount to plan the $8 billion a year business of health care doesn't strike me as exhorbitant. Health planning is "highly politicized" because health policy is not made by planners or physicians, but by politicians, which tends to politicize the process. I agree it is time-consuming. Whether it is, "ineffective" and/or "disruptive" in my experience depends on how one's interests were reflected in the planning product.

With respect to Medicaid, I point out the technical error that the $2.3 billion expenditure he indicates is roughly twice the actual anticipated expenditure for the next fiscal year.

He further points out that Medicaid provides "little more actual health care than a fraction of those dollars bought pre-Medicaid." I am not sure what that means; but, if it implies that one million Michigan residents were getting anywhere close to $1.2 billion worth of care for "free" prior to Medicaid, I am awestruck. While it is undoubtedly true that some physicians treated patients for free, it is hard to believe they absorbed $175 million a year of such costs. It is beyond my wildest imagination that Michigan hospitals and nursing homes provided $880 million of free care or that Michigan pharmacies gave away $103 million worth of drugs at any time prior to Medicaid reimbursement.

With respect to the HMOs, he indicated that "it's about time to end discriminatory subsidies." I point out that 90 percent of the cost of physicians' undergraduate education is paid by the state and federal government, and that most GME is paid by third party sources, 40 percent of which are governmental.

I agree with his overall thrust that "we can do better" and ". . . should assume the responsibility of positive leadership."

The rhetoric in his article and this letter are not conducive to addressing our mutual objective or obtaining our mutual goal.

Jay G. Endsley, Director
Office of Health and Medical Affairs

Doctor Ylvisaker responds:

Dear Jay,

I'm pleased you read the President's Page. I particularly welcome and appreciate your thoughtful "I take issue" comments. Let me respond.

On the "technical error" of Medicaid expenditure you are right; I was wrong. I obtained the figures from your office but either the question or the answer was misinterpreted. The $2.3 billion represents *all* government health expenditures in Michigan in the last budget year. The $1.1 to 1.2 billion represents the budgeted Medicaid dollars for the next fiscal year. I regret the error. Regardless, the *magnitude* of government spending is at issue and must be checked.

Further to the Medicaid comments: In 1965 the state budget estimate for cost was $60 million. This was changed *within* that year to $100 million. Fifteen years later we're spending $1.2 billion — twenty (20) times the amount of the first-year estimate, twelve (12) times the first year actual! The difference does strike awe, even when inflation of 2½ times is factored into the value of dollars. Believe me, prior to 1965, physicians and hospitals provided *needed* care *free* in a volume that few appreciated. I was there and part of the system. What we did bill was billed at greatly discounted rates — willingly — but was not subjected to the costs of paper requirements, dis-

continued on page 275

The 1981 MSMS House of Delegates, in photos

Top MSMS officers and councilors strike a formal pose following their electio at the May 1-3 MSMS House of Delegates meeting at the Troy Hilton. From lef they are James H. Tisdel, MD, Port Huron, president-elect; James D. Fryfogle MD, Southfield, president; Thomas R. Berglund, MD, Portage, Council chair man, and Carl A. Gagliardi, MD, Lincoln Park, Council vice chairman.

Presidential Citations were awarded at House of Delegates ceremonies to two distinguished, long-time Michigan publi health servants. They are John L. Isbister, MD, Lansing, right, who retired this year as state disease control officer; an Robert G. Rice, MD, Lansing, who retired as chief of the Bureau of Personal Health Services, Michigan Department o Public Health. 1980-81 MSMS President John R. Ylvisaker, MD, does the honors.

A highlight of the House of Delegates ceremonies honoring physicians who were graduated 50 years ago from medical school was the recognition paid to Donald Marshall, MD, and Evelyn W. Marshall, MD, Kalamazoo, husband and wife, who both have been physicians for 50 years. They joined 30 other long-time Michigan physicians in receiving MSMS 50-year pins.

)elegates and their guests enjoyed a picnic lunch at the 1981 Michigan Doctors ?olitical Action Committee annual luncheon May 2 during the House of Dele- ;ates meeting. They were led by, from left, St. Sen. Robert Vander Laan, (Grand ?apids), Senate Minority leader, speaker at the luncheon, and MSMS Council :hairman Doctor Berglund, who is on the American Medical Political Action :ommittee Board.

The new MSMS president, James D. Fryfogle, MD, left, is a barbershop quartet performer, and proved it when he joined the entertainers at his gala installation banquet.

ʌSMS delegates were delighted to :ee Elizabeth Blondy, 6, daughter of ʌarshall J. Blondy, MD, Livonia, :hose her daddy's lap to await :eremonies in which Doctor Blondy :eceived an MSMS Flag Award as ›resident of the Michigan Child ?assenger Safety Association. Flag ‹wards went to several Michigan ›hysicians who are presidents of :tatewide, nonmedical organizations; ʌichigan MDs who are presidents of ıational medical organizations also :eceived awards.

?hotos by Mert Scholten ınd Rod Rieser

New MSMS councilors elected at the House of Delegates meeting are, from left, Kenneth B. Herrington, MD, Bad Axe; Kenneth J. Ray, MD, Trenton, and Frank B. Walker, MD, Detroit.

1980-81 MSMS Auxiliary President Donna Chase, Grand Rapids, disappears in the bear hug of Michigan State University College of Human Medicine Dean W. Donald Weston, MD, as he receives the medical school's AMA-ERF check from the auxiliary. Checks also were presented to the other medical schools at the House of Delegates meeting.

A large Michigan medical student contingent to the MSMS annual meeting wa successful in its efforts to establish a student section and direct MSMS studen membership provisions. They are, from left, standing, Paul Kienbaum, Michigan State University; Tom Prose, University of Michigan; and David Wright Wayne State University; while seated, from left, are Rick Quinonas, U-M; Lis Hacker, U-M, and David Alessi, WSU.

putes over amounts, unrealistic patient demands, or imposed hard costs of running a business which go unrecognized and inadequately reimbursed. And then there's the liability of "malpractice."

But the major difference lies in the *demand* for services which has been undeniably fueled by the promises of the Medicaid system; promises for an extent of care that the system cannot pay for; promises that the government then unilaterally refuses to pay for and instead creates a hidden tax on the providers and their non-Medicaid patients by failing to pay costs. The "free lunch" is truly not free.

In my discussion I said "actual" health care. The word "needed" or "productive" would have better represented the thought intended. Yes, there are more services delivered, but in different and higher cost settings, based on demand often not fully representing true need, and not with a productivity in health benefits commensurate with expended dollars.

Health care providers have important insights based on experience. One of those insights is the recognition that there must be some semblance of financial responsibility (or undisputed need) before health care services are properly respected, utilized and valued. Physicians' disillusionment certainly is reflected in the progressive drop of "participating" physicians to about 50 percent of all practicing physicians nationwide, and an alarming drop statewide. But please note, I said Medicaid was a "mixed blessing." I staunchly support the providers and patients whose use of the system fulfills its recognized altruistic intent.

On health planning: the $6.2 million cost to Michigan government ($7.4 million including your department) is not at issue. What is at issue is the huge cost in time and productivity extracted from the industries and organizations who must pay their representatives to spend "volunteer" effort in the process (physicians along with housewives are not paid but do lose time and productivity in their own endeavors). Consider the cost of extra manpower layered into health care institution budgets, manpower hired to meet the requirements of submissions, redrafting, resubmissions of plans and applications, the cost also of institutional internal activity plus external activity to achieve consensus and support. Consider the inflationary increase in costs of projects and equipment which results from the time delays of the approval process. And then let's admit that most plans get approved anyway!

HMO's: You avoided the issue of the status of HMO subsidies and countered with education subsidy comparisons. I don't find these relevant any more than the subsidies for agriculture, transportation, or energy. With the HMOs, the point is that the government is touting *cost-efficiency*, but warping the results with the non-competitive advantage of dollar subsidies and special exemptions from industry-wide regulatory restrictions.

To the real point, the main thrust of my article: *We must reduce our dependence on government*. We must begin to free ourselves from the addiction of government doing for us what we can (and should) do for ourselves. The "cure" cannot be "cold turkey." The cure certainly can be measured, careful, but progressive "withdrawal" to a more rational maintenance dose.

I agree, rhetoric will get us no place. But we had better be willing to deal with reality, as unpleasant as that may be.

John R. Ylvisaker, MD
MSMS Past President

MSMS Director Warren F. Tryloff, right, applauds long-time MSMS leader Kenneth H. Johnson, MD, Lansing, during ceremonies in which the first-floor lounge of the MSMS headquarters building was named for Doctor Johnson in recognition of his dedication to MSMS programs. Doctor Johnson is former MSMS president, secretary, speaker of the House of Delegates.

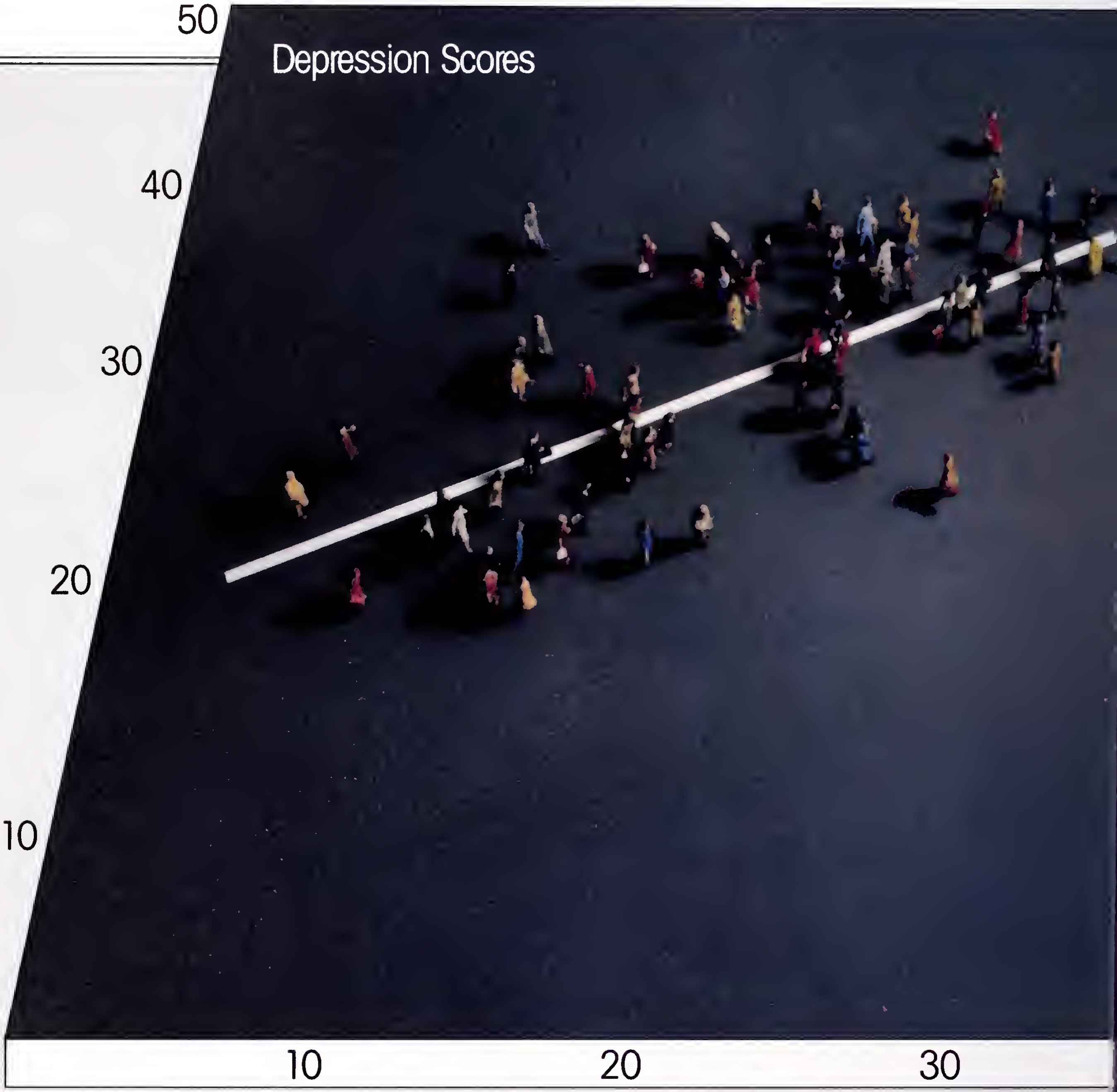
Correction

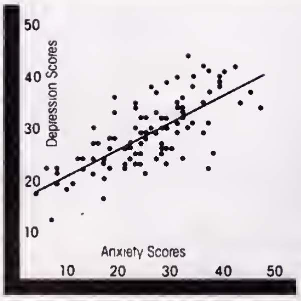
I would like to make a correction concerning a reference to me in the April, 1981 issue of *Michigan Medicine*. It stated that I practice internal medicine (IM). Rather it should state that I practice internal medicine/rheumatology (IM/RHU). I am trained in both fields, board certified in Internal Medicine, and board eligible for the next Rheumatology subspecialty examination. If it is possible, I would appreciate such a public correction in *Michigan Medicine*.

Thank you.

Thomas W. Henderson, MD
Staff Physician, Rheumatology
St. Joseph

FOR THE 7 OF 10 NONPSYCHOTI





Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3] Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE®

EPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]

Most depressed patients are also anxious. . .

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35:*1359-1365, 1978. **3.** Cloghorn J: The anxiety-depression syndrome. *Psychosomatics 11:*438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137:*1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61:*217-225, 1979.

In moderate depression and anxiety

Limbitrol® CIV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses Myocardial infarction and stroke reported with use of this class of drugs) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients Periodic liver function tests and blood counts are recommended during prolonged treatment Amitriptyline component may block action of guanethidine or similar antihypertensives Concomitant use with other psychotropic drugs has not been evaluated sedative effects may be additive Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment See Warnings for precautions about pregnancy Limbitrol should not be taken during the nursing period Not recommended in children under 12

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects

Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs

Cardiovascular Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue
Endocrine Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels
Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive I.V administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response Reduce to smallest effective dosage when satisfactory response is obtained Larger portion of daily dose may be taken at bedtime Single *h.s.* dose may suffice for some patients Lower dosages are recommended for the elderly Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12 5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50

ROCHE®
ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

Special report

Spotlight on the Michigan Delegation to the AMA

By Richard J. McMurray, MD, Flint

It is a real pleasure to have *Michigan Medicine feature* the AMA.

We who are involved with the AMA recognize it a an extension of our own MSMS. The AMA is an organization which has the know-how, the capacity and the talent to provide services for us, to provide a scientific base for us, to help guide health legislation for our patients and to speak for the profession on timely issues It also provides a code of ethics as a foundation on which each of us may base our own standards.

Michigan has eight delegates and eight alternate delegates. The attendance of these delegates at the meetings is fantastic. When you consider the financial los of their taking two weeks out of their practice eac

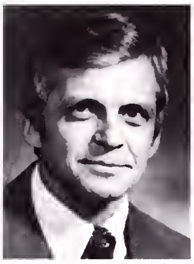
continued on page 28

Doctor McMurray is chairman of the Michiga Delegation to the AMA.

Meet Michigan's AMA delegates

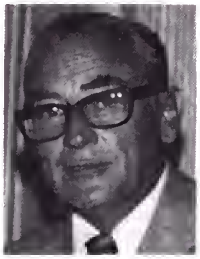
McMurray

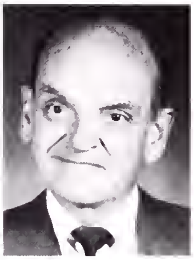
Allaben


Berglund

Burton

Crandall


Siegel


Sweeny

Walker

Richard J. McMurray, MD, Flint (University of Michigan, 1950). He is currently chief of obstetrics and gynecology at McLaren Hospital, Flint, and also serves on the staff of Hurley Hospital. Doctor McMurray is Chairman of the Michigan Delegation to the AMA House of Delegates and president of the Genesee County Medical Society. He is past president of the Norman F. Miller OB/GYN Society. He is chairman of the MSMS Committee on Federal Legislation and a member of the MSMS Judicial Commission.

Robert D. Allaben, MD, Detroit (Wayne State University, 1956). He is currently an associate professor in the Department of Surgery at Wayne State University, and serves as vice chief of staff and vice chief of surgery at Harper-Grace Hospitals, Detroit. Doctor Allaben is also president-elect of the Detroit Academy of Surgery, president of the Detroit Surgical Association, and director of the Michigan Society of General Surgeons.

Thomas R. Berglund, MD, Portage (University of Michigan, 1959). He has worked in family practice at Portage Medical Clinic since 1961, and is affiliated with Bronson and Borgess hospitals in Kalamazoo. Doctor Berglund is MSMS Council Chairman, past chairman of Michigan Doctors' Political Action Committee, and a member of the board of the American Medical Political Action Committee. He is past president of the Kalamazoo Academy of Medicine.

Robert D. Burton, MD, Grand Rapids (University of Michigan, 1953). He is now an attending physician at Blodgett Memorial, St. Mary's and Butterworth hospitals and also is associate clinical professor in the College of Human Medicine at Michigan State University. His specialty is otolaryngology. He is past president of the Grand Rapids Hearing and Speech Association and of the Kent County Medical Society.

Donald K. Crandall, MD, Muskegon (University of Michigan, 1963). He currently serves on the Medical Staff Executive Committee of Hackley Hospital, and is an active staff member (surgery) at Hackley and Mercy hospitals. He also serves as consulting staff at North Ottawa Hospital, Grand Haven. Doctor Crandall is vice president of the Greater Muskegon HMO, and serves on the boards of the Michigan Society of General Surgeons and of the Michigan Association of the Professions. He is the AMA delegation's representative to the MSMS Council and is past president of the Muskegon County Medical Society.

David Siegel, MD, Lansing (New York Medical College, 1948). He is past chief of staff and currently vice president of medical affairs at Sparrow Hospital in Lansing. Doctor Siegel is also past president of the Michigan Urological Society. He is speaker of the MSMS House of Delegates and immediate past chairman of the MSMS Medicaid Liaison Committee.

Donald N. Sweeny, Jr., MD, Detroit (Harvard University, 1940). He is past chief of surgery at Bon Secours Hospital, Grosse Pointe, past president of the Detroit Academy of Surgery, the Detroit Surgical Society, and the Wayne County Medical Society. He is on the board of the National Association of Blue Shield Plans, and is past chairman of the AMA Council on Medical Service. He is former member of the MSMS Judicial Commission, and the Council, and of the Michigan Medical Practice Board.

Frank B. Walker, MD, Detroit (Wayne State University, 1955). He is president of the Michigan Society of Pathologists and immediate past president of the American Society of Clinical Pathologists. He serves on the Board of Trustees of the Detroit-Macomb Hospital Association and Alexander Blain Hospital and is secretary of the medical staff at Cottage Hospital. Doctor Walker is a full time staff member of Detroit-Macomb, Cottage, and Alexander Blain Hospitals, and is a clinical faculty member at Wayne State University.

Opening ceremonies of the AMA House of Delegates are colorful.

What the Michigan Delegation proposes:

Michigan delegates to the AMA Annual Meeting June 7-11 were to take part in reorganization of the federation.

The key issue in the 89 resolutions and 58 special reports to be presented was streamlining of the AMA's organizational structure to effect economies in programs and to establish a three-year dues policy.

The AMA Board of Trustees early in April announced its recommendations for a "leaner but more effective" AMA. They include an incremental approach to the dues structure, and consolidation of programs and staff to make the association more flexible and responsible to issues. The delegates were to be asked to endorse the board's recommendations.

Michigan's delegates were to introduce four resolutions, each of them directed by the MSMS House of Delegates. They were:

1) That the AMA seek federal legislation to provide exemption from anti-trust laws, similar to that granted organized labor, to allow for discussions between organized medicine and third party payers when a single service benefit third party payer enrolls more than one-third of the population of a state, or one-fourth of the population of any county.

2) That the AMA seek federal legislation to repeal certificate of need statutes.

3) That the AMA oppose implementation of the authority of the Secretary of Health and Human Services to conduct proficiency testing programs of any kind from the national level as stated in Section 911 on the Omnibus Reconciliation Act of 1980 (PL 96-499).

4) That the AMA work with other interested national associations to develop a strategy to accredit jails and other correctional health care programs on a permanent basis; that the AMA continue its current correctional health care program at the AMA headquarters; and that the AMA fiscal commitment be appropriately reduced by the substitution of accrued, private, state and federal funds.

Richard J. McMurray, MD, Flint, is Michigan delegation chairman. Delegate Robert D. Burton, MD, Grand Rapids, is serving on one of the AMA reference committees. Other delegates are Robert D. Allaben, MD, Farmington Hills; Thomas R. Berglund, MD, Portage; Donald K. Crandall, MD, Muskegon; David Siegel, MD, Lansing, Donald N. Sweeny, Jr., MD, Detroit; and Frank B. Walker, MD, Grosse Pointe Farms, who is delegation vice chairman.

Alternate delegates, in the order in which they are called to serve, are George M. Wilson, MD, Marquette; Richard H. Gascoigne, MD, Adrian, Gerald H. Mandell, MD, Southfield; Carl A. Gagliardi, MD, Lincoln Park; Louis R. Zako, MD, Dearborn Heights; Jay K. Harness, MD, Chelsea; Robert E. Paxton, MD, Fremont, and Billy B. Baumann, MD, Pontiac.

AMA's House of Delegates most democratic organization in the world

By John J. Coury, Jr., MD, Port Huron

In this brief discussion, it is my objective to explain the purpose and function of the American Medical Association.

Unfortunately, most physicians do not realize that the most democratic, deliberative organization in the world is the House of Delegates of the American Medical Association — its policy making body.

It is composed of 279 members representing state medical associations, national medical specialty societies, medical school sections, resident physicians, medical students, and the service sections composed of Army, Navy and Air Force Medical Corps as well as the Public Health Service and Veteran's Administration. I'm sure you now realize that the American Medical Association is representative of *all* physicians in these United States.

AMA organization

The House of Delegates elects the president of the association as well as the speaker and vice speaker of the House of Delegates and the 12 members of the Board of Trustees.

The Board of Trustees is composed of the president, president-elect, past president and 12 trustees who are voting members. The speaker and vice speaker are non-voting members of the Board. The Board elects its chairman, vice chairman, its executive committee and the secretary-treasurer of the association.

Doctor Coury has been a member of the AMA Board of Trustees five years, and is a member of the AMA Council on Long-Range Planning and Development.

The Board of Trustees carries out the policies of the House of Delegates and acts for the House when it is not in session. Attendance at Board meetings takes priority over all other duties of the Board members. In fact, during the five years that I have had the privilege of serving as Trustee, I would say attendance has been essentially 100 percent.

The American Medical Association has approximately 240,000 members. The fastest growing memberships are resident and student sections. The membership is serviced by its Executive Vice President, James H. Sammons, MD, and his staff of over 850 individuals. They are an efficient staff.

Our budget for 1981 will be approximately $69 million — just about equal to income. Approximately 54 percent of the revenue will come from dues, the remainder from various investments. Since 1975 and zero-based budgeting, the AMA has become a strong financial organization.

"It is the responsibility of the American Medical Association, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people." This it does by expending over 65 percent of its budget for that purpose. The remainder goes toward service to its members, administration and representing the profession. About 1.2 percent goes toward representing the profession in Washington, DC.

There is only one organization that can represent all physicians on the national level and that is the AMA. As a former HEW Secretary has stated, "If the AMA would disappear today, another would have to be formed tomorrow."

The voice of medicine on Capitol Hill is the AMA — to represent and protect the health of the public and to represent and protect the medical profession. Without the AMA we would not have the freedom to practice medicine that we now enjoy. Without the AMA the quality of care would not be the world's best. Without the AMA and its standards for decades we would probably not have the quality of medical education that we now have.

Washington voice

Over the years the AMA has testified and supported thousands of bills and programs in support of better health care for the public, such as immunizations, improved medical care for the underserved, the blind, deformed, veterans, the diabetic, the cardiac, etc. Of all the legislative health bills introduced over the past many years, we have supported over 90 percent. The AMA has been negative toward less than 10 percent, and that position was taken only to protect the public and the profession.

During the past few years, the AMA has expended considerable effort and finances defending the profession against unfounded allegations from scientology, chiropractic and the Federal Trade Commission. Millions of dollars of expense have been accrued — unfortunate but necessary. We have been successful against scientology and chiropractic but somewhat frustrated by the intrusions of the FTC, requiring us to appeal to the US Supreme Court where we hopefully will be successful.

Despite these financial burdens, the AMA has continued to be a strong and financially sound representative organization of American medicine. Our goal is to keep it strong, organizationally and financially.

During the next decade medicine faces many serious problems; e.g., demanding consumerism, increasing

DOCTOR McMURRAY/*continued*

year, I believe they all deserve a great deal of credit.

Our delegation is a team which works diligently to bring to the AMA the concerns and desires of our Michigan constituency. Each alternate and each delegate has equal voice in our delegation. At the present time members of the delegation are developing their interests in specific fields, such as medical education, legislation, insurance, third party pay, and public health, so that they may speak with some expertise on the subject. These delegates or alternates then testify at the respective reference committees and are seated on the floor of the house when the report is presented. We use our alternates just as we do full delegates, who move on and off the floor as the subject matter dictates.

At the 1981, AMA annual meeting June 7-11 in Chicago, your delegation will be starting each day at 6:30 AM. We will review all the reports of the trustees and the various councils and also the resolutions which are presented. We discuss these along with the impact they may have on matters in our state and decide if we can support the issue. The final question we always try to ask is: will the decision we make be consistent with MSMS policy and will it be beneficial to our patients and our physicians back in Michigan?

Political activity at the AMA is time-consuming, sometimes boring, other times exciting and usually enjoyable. My biggest personal enjoyment comes from being kept informed on matters pertaining to health care delivery, medical education, and other key subjects. The Michigan delegation will attempt a new method of interviewing candidates this year, combining our group with four other states, but each maintaining our own selection independence.

Our delegation has been relatively successful in promoting candidates in the last few years. Donald N. Sweeny Jr., MD, Detroit, recently retired from the AMA Council on Medical service, of which he was chairman 1976-1978. This is a very hard-working and busy council. George W. Slagle, MD, Battle Creek, was a recent vice president of the AMA. He has now retired after many years of valued service with the Michigan delegation to the AMA. John J. Coury Jr., MD, at present is a second-term member of the board of trustees and chairman of the finance committee. Our most recent political endeavor was to help James Potchen, MD, East Lansing, attain a seat on the Council of Medical Education. Jim is an alternate delegate for Nuclear Medicine. Michigan gave him the base which allowed him to present a vigorous and successful campaign.

As your delegation prepares for the Chicago meetings in June it will turn its attention to the resolutions which you have directed us to take to the AMA House. Issues which are presently AMA policy and under active pursuit by the Board or Councils will not be duplicated unless we feel the need for reinforcement.

It seems that at each meeting there develops a key agenda item. This year it would appear that item will be organizational changes and consolidation of programs in an attempt to reduce expenses. A correlative item will be an incremental approach to dues increases beginning in 1982.

I will repeat the oft-heard fact: it takes 20,000 new dues-paying members each year to keep up with inflation. The escape from higher dues is membership recruitment. The answer to membership recruitment is an eyeball to eyeball approach to our non-member colleagues.

DOCTOR COURY/*continued*

regulations, rapidly increasing manpower and competition, proliferation of medical liability problems, inflation, intrusion into the practice of medicine by other "health providers," increasing demands for service, rapidly advancing technology, maldistribution of physicians, impaired physician problems, restrictive licensing, unethical advertising by some members of the profession, the opportunistic or fraudulent practitioner and many other problems.

I can assure you the AMA will remain alert to protect the public and the profession and I promise you that it will not abrogate its responsibility.

Honored, proud

Now a bit of personal privilege — as the first Michigan physician to be a member of the AMA Board of Trustees, I feel deeply honored, proud and humble. As a trustee I represent all physicians of our country. However, like all other trustees, I have a sentimental allegiance to my state society. I thank you all for the opportunity.

Michigan can be proud of its delegates and alternate delegates to the AMA. They are an outstanding group of highly ethical and capable physicians who are second to none in the House of Medicine. They too represent not only Michigan physicians but physicians throughout our country. All physicians who believe in quality medical care and the freedom to practice medicine have an obligation to join and support their county, state and American Medical Association.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

Get in tune with MSMS/A

By Barbara (Mrs. Lawrence) Grennan, Muskegon

Membership seems to be one of the challenges of the Eighties and we, the Michigan State Medical Society Auxiliary, are having to confront that problem this year. Our auxiliary members are being asked to lend their efforts to a major thrust in this area. Faced with a continuing decline in membership figures, we have given this our number one priority for 1981-82.

Since 1979, our numbers have decreased by more than 200 state, and over 300 national members. Where once we were proud to boast of our 3,000-plus membership, we now have a state membership count of 2,518 and a national total that stands at 2,413. These declining figures are representative of a problem not only in Michigan but one which is occurring in other states as well and one that must be faced and solved.

Part of this membership loss can be laid to a dues increase by the American Medical Association Auxiliary. But that does not explain the reduction in state figures, where there has been no dues increase. We must accept some responsibility for not satisfactorily explaining the need for this increase to our members and further for not making them aware of the ways in which these dues dollars are returned to them.

More importantly, however, we must take a long, hard look at what we offer our members, to determine if we are meeting their needs. If we are not, then we must assess the effect that has had on our membership drop. If we have indeed failed to sell our members on our worth, we must take immediate steps to reverse their negative attitude and reactivate their positive response to us.

Hard look needed

At our annual convention in April I asked three questions of our members:

Are we selling ourselves short?

Do we have the skills and willingness to use them as a positive force in our communities?

Are we willing to be spokesmen for, or an emblem of, medicine?

The answers to these questions may be the answers to our membership problems.

We have sold ourselves short in the past by not responding sooner to the lack of relevant programs for our members. Many of our active members have reached a point where their interests are diversifying and their enthusiasm waning. They have left the doing to someone else.

That someone else is the newer members of auxiliary who are more individualistic and not content with just following the patterns of their predecessors. These are the people we must reach, with programs suited to their needs and interests.

Are we selling ourselves short? Not any more — we are embarking on a series of programs designed to challenge and interest everyone.

Do we have the skills and willingness to exert a positive force in our communities? Of course! We are a multi-talented group of people who are constantly initiating and implementing projects that respond to challenges from within our environment.

Are we willing to be spokesr or emblems of medicine? Withou doubt! We have a fundamental in est in the advancement of medic and its image to the public. Since spouses derive their income from practice of medicine we are m than willing to be a representative them.

What we're doing

To respond to the challeng these questions, new, and we h more relevant, programs are being itiated this year to interest and ex our members:

1. Slide presentation of MSMSA activities and resources.
2. Consultants to counties specific subjects as reques through our Education Committe
3. The MSMS/MSMSA Leadership Conference, Octo 21-22 in Lansing.
4. Educational resource m rials to the counties at no charge benefit of their state auxiliary m bership, and
5. A joint project of MSMSA MAHA (Michigan Associatio Hospital Auxiliaries) in coopera with the Michigan Associatio Medical Assistants and Blue Cr Blue Shield of Michigan enti "Understanding Health Care Co age of Older Adults." This prog will attempt to provide informa about the Medicare program, its l tations and procedures, as well definition of terminology and an planation of the forms required reimbursement of medical care c

We are attempting to provide members with some new progr and ideas to encourage their par pation in our state and national ganization. Isobel Dvorsky, AMAA president-elect, has defi membership in auxiliary as a q tion of priority, not dollars. If programs have worth we should ily be able to establish our plac our members' priority system. To end we are inviting our Michi State Medical Society Auxil members to:

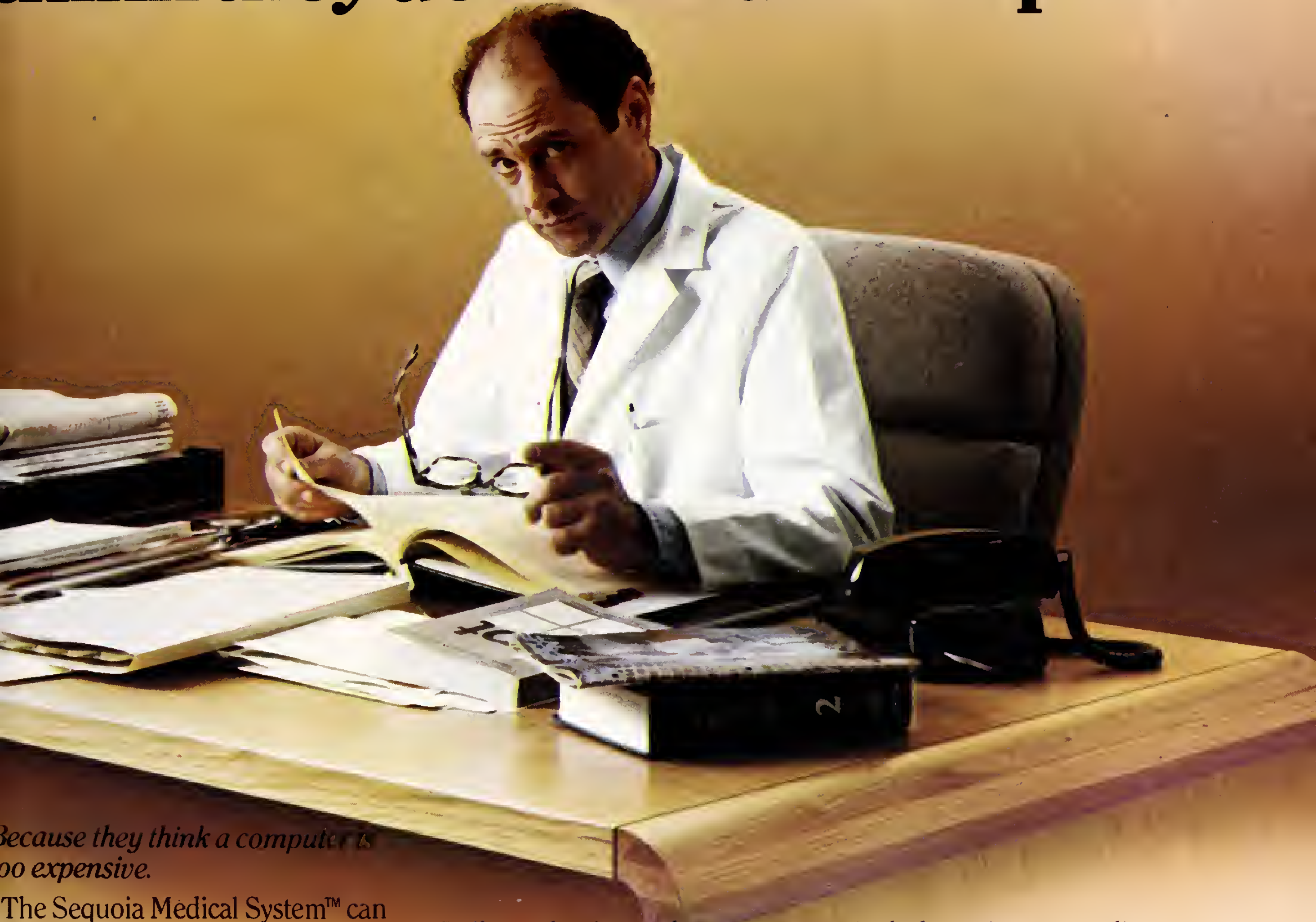
TUNE IN to auxiliary,

TUNE ON with our new grams, and

TUNE UP themselves and t county membership, to make 198 a NOTEWORTHY year.

Mrs. Grennan is president of MSMS/A.

We're looking for doctors who think they don't need a computer.



Because they think a computer is oo expensive.

The Sequoia Medical System™ can pay for itself:
- Increased collections
- Decreased receivables
- Improved staff efficiency

Because they think they already ave firm control of their billing.

The Sequoia Medical System automatically processes billing paperwork:
- Patient statements
- Third party claims
- Collection letters

Because they think they have asy access to vital practice data.

The Sequoia Medical System provides information immediately:
- Aged receivable reports
- Procedure and diagnosis analysis
- Daily production and revenue analysis
- On-line access to 4½ million medical journal articles in the National Library of Medicine
- And many other forms of essential data

Because they think a computer is administratively disruptive.

The Sequoia Medical System is designed to blend smoothly into solo and small group practices:
- Easy to use
- Pre-programmed, turn-key system
- Includes training, installation, local service and support.

Because they haven't seen a Sequoia Medical System.

Sequoia can provide more time for health care in your practice. While it's taking care of business... you're taking care of patients.

Start looking into the benefits of a computer today by calling Sequoia Group. Call toll free (800) 227-2360; in California (800) 772-2655... or write for our brochure.

SEQUOIA GROUP™
INCORPORATED
1100 Larkspur Landing Circle, Larkspur, CA 94939
Atlanta, Birmingham, Boston, Buffalo, Charlotte, Chicago, Cleveland, Columbus, Dallas, Denver, Detroit, Hartford, Houston, Indianapolis, Irvine, Kansas City, Los Angeles, Memphis, Miami, Minneapolis, Nashville, New Orleans, New York City, Norfolk, Oklahoma City, Philadelphia, Phoenix, Pittsburgh, Portland, Salt Lake City, San Diego, San Francisco, Seattle, St. Louis, Tampa, Washington, D.C

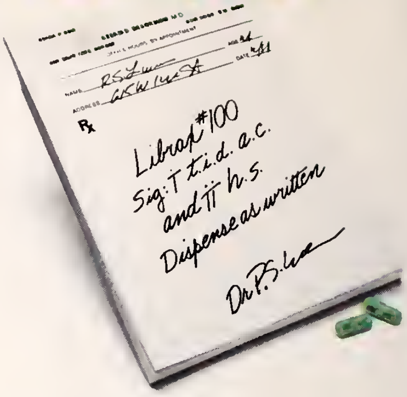
Ready to teach home nursing, first aid, parenting, child care, water safety, CPR.

Red Cross:
Ready for a new century.

1881
1981

A Public Service of This Magazine
& The Advertising Council

Specify
Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated) Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines Observe usual precautions in presence of impaired renal or hepatic function Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges Syncope reported in a few instances. Also encountered. isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

ROCHE®
Roche Products Inc
Manati, Puerto Rico 00701

n Duodenal

ULCER* MANAGEMENT

The proven antispasmodic and antisecretory actions of Quarzan® (clidinium bromide/Roche) for the ulcer

The well-known antianxiety action of Librium® (chlordiazepoxide HCl/Roche) for the accompanying anxiety found in many ulcer patients

Specify Adjunctive Librax® ROCHE®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

Antianxiety/Antisecretory/Antispasmodic

rax has been evaluated as possibly effective for
is indication. Please see brief summary of pre-
ribing information on facing page.

otograph of simulated gastric hypersecretion.

Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.

5
40
35
30
25
20
1
getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate® Dospan® ⒸIV

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate–it makes sense.
And it's responsible medicine.

Merrell

Tenuate® ⒸIV
(diethylpropion hydrochloride NF)

Tenuate Dospan® ⒸIV
(diethylpropion hydrochloride NF)
controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states Patients with a history of drug abuse During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result)

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe There are reports of patients who have increased the dosage to many times that recommended Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks *Use in Children* Tenuate is not recommended for use in children under 12 years of age

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias Tenuate should not be administered to patients with severe hypertension Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics Therefore, epileptics receiving Tenuate should be carefully monitored Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses In a few epileptics an increase in convulsive episodes has been reported *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances *Allergic*. Urticaria, rash, ecchymosis, erythema *Endocrine* Impotence, changes in libido, gynecomastia, menstrual upset *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger Tenuate Dospan (diethylpropion hydrochloride) controlled-release One 75 mg tablet daily, swallowed whole, in midmorning Tenuate is not recommended for use in children under 12 years of age

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states Fatigue and depression usually follow the central stimulation Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

Product Information as of January, 1980

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to
MERRELL DOW PHARMACEUTICALS INC
Subsidiary of The Dow Chemical Company
Cincinnati, Ohio 45215
Licensor of Merrell™

References: 1 Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga, M T. et al: A comprehensive review of diethylpropion hydrochloride In Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed , New York Raven Press, 1978, pp 391-404

MSMS group health premiums up due to rising costs, improved programs

By Donald G. Blain, MD, Utica

Premiums are up substantially for MSMS members insured under the MSMS 94000 group health insurance program.

But there are reasons, and one of them is that coverage has improved.

Premiums have increased approximately 30 percent, or $40, per family insured in the MSMS group plan for 1981.

The principle reason, according to Gae Ellery, Blue Cross Blue Shield of Michigan, plan administrator, is that the Blues paid out 20 percent more on MSMS members' claims in 1980 than they received in members' premiums. In dollar figures, the MSMS group health plan paid out in 1980 over $500,000 more than it earned.

At the same time the MSMS group insurance program has been upgraded, with the addition of master medical, which covers a major portion of out-of-pocket expenses due to catastrophic illness or injury.

In addition, our task force is working to offer an optional dental program and a comprehensive health insurance plan with high deductibles and low premiums. Both the optional dental coverage and the comprehensive health plan were mandated by the MSMS House of Delegates at its recent 1981 annual session in Troy.

The latter plan is expected to appeal to physicians up to age 65, who do not wish to pay high premiums, and, evaluating their health status, are willing to pay a larger share of their costs. The probable deductible would be $1,000 per individual, $2,000 per family.

The comprehensive coverage also will be offered to physicians' employees, who would not be offered as big a cut in premiums, but also would have a significantly lower deductible. Persons on Medicare would not be eligible.

Fifty percent of MSMS members are covered by the Group 94000 plan, says Ms. Ellery. They received a total of $6,912,748.26 in health insurance payments in 1980.

The largest amount, $3,563,424.70 went for inpatient facility services, with MSMS members as patients one-third of the time, and their dependents two-thirds. Inpatient facility services payments accounted for 51.5 percent of total.

The second largest amount, $952,989.77, was paid for physician services in the hospital. That was 13.8 percent of the total paid out, and three-fourths of the amount was for services to MSMS members' dependents.

The average charge per day for members' inpatient hospital care was $422.70. It was lower — $326 — for their dependents' inpatient facility services. We might speculate that members were hospitalized for more serious and advanced conditions, requiring more intensive and expensive care.

MSMS members also had longer stays in the hospital than did their dependents — 6.90 days per case, compared to 6.67 days per case.

The most frequent type of care provided MSMS members and their families under the Group 94000 plan was surgery (44.94 percent), followed by inpatient medical care services (21.76 percent), and institutional psychiatric services (8.79 percent).

Average charge per day for institutional benefits was $517.07. Members themselves had a larger percentage of payments for surgical and inpatient medical care and higher average charge per day than did their dependents. Their dependents, however, had twice the percentage of payments for institutional psychiatric care as did members.

The most frequent diagnosis for institutional care of members insured by the Group 94000 plan was diseases of the circulatory system, while their dependents were most frequently hospitalized for complications of pregnancy and birth and for mental disorders.

MSMS group plan members had about 28 percent fewer services per 1,000 members than did other groups insured by BCBSM. However, the payment per service was about 25 percent higher for MSMS members than for other BCBSM group members.

Average hospital length of stay was longer for MSMS group members than for Blue Cross group members in Michigan and across the country, by 1.9 percent and 10.6 percent, respectively. Hospital admissions for MSMS group insurers were significantly fewer than the state (28.9 percent) average, but the charges per day were higher (5.9 percent).

Doctor Blain is chairman, MSMS Task Force on Member Insurance Plans.

"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

PAVABID® AND PAVABID® HP
(papaverine hydrochloride)
150-mg Capsules 300-mg Capsulets

Patient benefit products from

PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY MO 64137

6/80

Athletic conditioning the topic of 1981 MSMS Conference on Sports Medicine

By Kim Dean, special to Michigan Medicine

A highlight of the 1981 MSMS Sports Medicine Conference was the presentation of an MSMS Presidential Citation to Western Michigan University Director of Athletic Education Jack Jones, right, for his years of service to athletic medicine and close cooperation with MSMS as an advisory member of the MSMS Sports Medicine Committee. Mr. Jones has been at WMU 25 years and is former head trainer for WMU teams. Presenting the award was committee member Richard Lemmer, MD, Kalamazoo, center. They are joined above by conference speaker and Michigan State University Athletic Director Douglas Weaver.

Keynote speaker at the conference on athletic conditioning was top ranking road racer in the nation, Herb Lindsay, Boulder, CO.

Over-training and deconditioning are very real phenomena among athletes.

This is according to the 1981 MSMS Conference on Sports Medicine keynote speaker, Jack Wilmore, PhD, exercise physiologist from the University of Arizona. His discussion, entitled the "Physiology of Conditioning," zeroed in on acute responses to exercise and chronic adaptations to exercise.

"Athletes," said Wilmore, "can reach peak condition pre-season and ignore conditioning throughout the playing season." He stressed the importance of year-round conditioning for athletes, to avoid serious drops in conditioning once their season starts.

The 15th annual MSMS Conference on Sports Medicine was entitled "before the contest." One hundred seventy-five physicians, coaches, trainers and students turned out at Western Michigan University for the seminar.

The topic of discussion was conditioning before the contest, as taken from the perspective of the physician, trainer and athlete. "The theme was adopted," said Doug McKeag, MD, this year's conference chairman, "to enhance the structure of the meeting and cover a wider variety of topics from different viewpoints."

In his assessment of the orthopedic screening exam, Herb Ross, DO, Consulting Team Orthopedic Surgeon for Michigan State University, emphasized that current pre-participation exams are conducted too closely to playing time. In most instances, he said, the exam is administered with no time for further conditioning and correction of problems. Doctor Ross encouraged early examination to prevent possible problems.

Herb Lindsay, former Michigan State University track star and current top-ranking road racer in the nation, said there are several key elements to the success of general training. "Goalsetting," said Linday "should be realistic, yet serve as challenge and a source of motivation." He said striving for a comfortable routine, while avoiding monotony, is the key to maintaining low stress levels and improved performances.

From a high school trainer's viewpoint, Tom Mackowiak, ATC from East Lansing High School, cited an increasing number of young women athletes suffering from inflammations, especially those involved in swimming and cross country running. He felt that restoring the high-school athlete to a pre-injury state is an area of major concern "The effort of the coach in making the injured player feel like part of the team is an instrumental element o the rapid recovery and heightened attitude of the athlete," said Mackowiak.

Ms. Dean is a public relations student intern with MSMS.

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

Many physicians will not have disability income protection to replace their loss of income...Most physicians will not have professional overhead coverage to pay their ongoing office expenses.

Will you be one of these physicians..."It won't happen to me."

Your MSMS group plans can provide this needed protection. For more information about rates and applications call toll free, 800-292-1966.

"we're here to help"

Stratton-Cheeseman & Associates, Inc.
1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823

*1979, The National Underwriter Company

Mean charge for physician office visits $21.29; average wait for appointment 7.0 days

By Martha Climo, special to Michigan Medicine

The National Center for Health Services Research (NCHSR) has issued two more analytical reports on critical national health policy issues: "Charges and Sources of Payment for Visits to Physician Offices" and "Waiting Times in Different Medical Settings: Appointment Waits and Office Waits." These reports emerged from the Center's study on how Americans use health care services and what the patterns of health expenditures and insurances are.

Payment for visits

In the report, "Charges and Sources of Payment for Visits to Physician Offices," particular attention was given to differences in charges and the extent of third-party payments for different groups in the population for the period Jan. 1-March 31, 1977.

According to the report, the mean charge for physician office visits was $21.29. The patient or his/her family paid an average proportion of $14.69. Other sources paid the remainder: private health insurance paid an average of $3.41; Medicare, an average of $0.85; and Medicaid, an average of $1.49.

The report revealed the following information: the mean charge per physician office visit was lowest for children six years of age or younger. Although families pay a larger, average proportion of the charge than does any other payment source, the charge lessened slightly as the age of the patient declined. No statistically significant difference existed between the mean charge and average proportion of each paid by the family for males and females. The mean charge for visits did not differ between whites and all other groups.

The mean charge for visits ranged from a high of $28.10 for persons with 16 years or more of education compared to $18.91 for persons with 11 years or less. There was a difference in amounts paid by private health insurance for persons with 13 to 15 years of education and for those with 11 years or less. As levels of education increased, the average proportion paid by Medicaid declined.

The mean charges were higher for residents of standard metropolitan statistical areas (SMSAs) than for those living in other areas. Mean charges were higher in the West than in the North Central Region, the Northeast and the South.

The mean charge for persons reported in excellent health was on the average higher than for persons reported in good health. The average proportion of the charge paid by the family declined as perceived health status declined; the opposite was found for the average proportion of the charge paid by Medicare and Medicaid. The family and private health insurance remain the largest payers for physician office visit charges for all health status categories. However, for persons in less than excellent or good health, Medicare and Medicaid assumed higher proportions of average visit charges.

Substantial variations were found among different age and color groups in the sources of payment for physician office visit charges. The most noticeable difference across age groups was in the proportion paid by the family for visits by white (0.78) and all other groups (0.49). While this difference was greatest for children under six years of age, it became less in each successive age group. The average proportion paid by the family decreased with age for whites and increased with age for all other groups.

While little or no difference existed by color groups in the proportion paid by private health insurance, substantial differences existed in the proportion paid by Medicaid. This was the case in the two youngest age groups and in the oldest age groups. Medicare paid very

continued on page 296

Leadership

It took time to achieve it
It takes dedication to keep it

Purepac became the largest generic drug manufacturing facility in the United States by providing high quality generic pharmaceuticals at the lowest possible cost. We know that to be on top tomorrow, we've got to stay a few steps ahead today. Here are some of the steps we've already taken:

- **Full-time Medical Vice President with Supporting PhD Staff**
- **ANDA/Patent Review Departments**
- **State Formulary Manager**
- **Regulatory Affairs Department**
- **Comprehensive Advertising and Marketing Support Programs**

It took Purepac 50 years to achieve this leadership position. And we're determined to provide you with even more quality products and dedicated services in the next 50 years.

PUREPAC PHARMACEUTICAL CO.
Division of Kalipharma, Inc., Elizabeth, N.J. 07207
1930-1981
Celebrating over 50 years of industry leadership.

GN-1080

Michigan medical students learning on the job this summer

By Michael Vella, special to Michigan Medicine

Students from three Michigan medical schools are now working in Medical Education Community Orientation positions in various hospitals throughout the state.

The objective of MECO is direct and strong: "To introduce the student to the organization and operation of hospitals and physicians and to the delivery of health care in the community." The project also helps students to better plan their medical education as related to specific community needs in health care.

Their position will endure only for the summer months, but many excellent students are asked to return again for the following summer break.

Eleven years ago medical students who wanted more experience in the field turned to the Michigan State Medical Society and their program called "MECO" (Medical Education Community Orientation). With the cooperation of hospitals and clinics, the project established itself as a strong program to acquaint the student with the practice of clinical medicine in a community setting. MECO is an annual program of the three chapters of the American Medical Student Association (AMSA) in Michigan. It enables both practicing physicians and other health professionals to become involved. The program is coordinated in 40 states including Illinois where the first program began back in 1969.

MSMS originated the project in 1970, but in 1979 the coordination and responsibilities were transferred to the Michigan Health Council. The Health Council receives assistance from MSMS, Michigan Hospital Association, and student advisors at the Michigan medical schools.

There are 23 students participating in the 1981 summer MECO program. Eleven pre-sophomore medical students are from Wayne State University, seven from Michigan State University and five from the University of Michigan. MECO participants spend six to eight weeks in the summer obtaining valuable knowledge of the hospital's services and of the neighboring community.

The health facility generally furnishes room and board for the students as well as a stipend. "The hospital has the opportunity to orient the student on the positive side of medicine in *that* community with the idea of encouraging the student to seriously consider practicing in that community upon graduation," explains Herbert A. Auer, former deputy director of MSMS and now the executive vice president of MHC.

The hospitals participating in the project this summer are Pawating Hospital, Niles; Clinton Memorial Hospital, St. Johns; United Memorial Hospital, Greenville; Sterling Area Health Project; Battle Creek Sanitarium Hospital; Hillsdale Hospital; Saline Community Hospital; Cottage Hospital of Grosse Pointe; Hackley Hospital, Muskegon; Scheurer Hospital, Pigeon; St. John Hospital, Detroit; Port Huron Hospital; and Standish Community Hospital.

Mr. Vella was a communication student intern from Michigan State University at MHC during 1980-81.

NCHSR REPORTS/*continued*

small amounts for all but the oldest age group regardless of color, reflecting the focus of this insurance program on those over 65. No differences between color groups existed in the proportion paid by other sources of payment.

Waiting times

According to the report "Waiting Times in Different Medical Settings: Appointment Waits and Office Waits," "Waiting times for an appointment can be a source of dissatisfaction with the delivery of medical care if the patient's view of the appropriateness of the waits differs from that of the physician or the person scheduling the appointment. Waits in the office or outpatient department can also be a source of dissatisfaction, if people must wait beyond their scheduled time, or if those making unscheduled or emergency visits wait longer than they consider reasonable."

During the period from January 1 to March 31, 1977, the average wait for an appointment in ambulatory care settings was 7.0 days. The waiting time for all types of services was longer in hospital outpatient departments (10.0 days) than in physician offices (6.9 days). For visits for specific preventive services, the average wait was much longer since the services are associated with less immediate need to see a physician than are other types of services. However, for visits not connected with preventive services, patients again experienced longer appointment waiting times in hospital outpatient departments than in physician offices.

The report further revealed the following information:

Waiting times were shortest for children less than six years of age. Females usually waited longer than males for an appointment. No statistically significant difference existed for appointments involving preventive services. The overall difference between color groups in waiting time for an appointment was about two days (7.2 days, white; 5.3 days, all others). For preventive services appointments, there was no statistical difference. People living in standard metropolitan statistical areas (SMSAs) waited roughly one day longer to see a physician than did persons living elsewhere.

Dissatisfaction with the delay between making an appointment and seeing a physician was generally low when the waiting time was from two to seven days. Even when the delay exceeded seven days, dissatisfaction was reported only 25 percent of the time.

However, dissatisfaction remained higher for visits not associated with preventive services. This suggests that the purpose of a visit is closely associated with the way patients feel about how long they must wait for a physician appointment.

Down with pain
Step up to reliable relief

for mild to moderate pain

Wygesic® (IV)

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers sedative-hypnotics, or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e g driving a car or operating machinery Patients should be cautioned accordingly

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group

PRECAUTIONS: Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness sedation nausea and vomiting These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as local or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea cardiac arrest, and death have occurred

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill, however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity, jaundice coagulation defects, hypoglycemia, encephalopathy, coma and death may follow Renal failure due to tubular necrosis and myocardiopathy, have also been reported

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone nalorphine and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered preferably I V , simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory In addition to a narcotic antagonist the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions

Oxygen IV fluids vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting and drowsiness Appropriate literature should be consulted for further information (JAMA 237 2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

Copyright © 1981, Wyeth Laboratories.
All rights reserved

Wyeth Laboratories
Philadelphia, PA 19101
TM

PAIN AND TENSION...
Double fault for
weekend warriors
ACE THE ACHE
with

Equagesic®(IV)

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

***INDICATIONS** Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use i e more than four months has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin meprobamate or ethoheptazine citrate

WARNINGS Careful supervision of dose and amounts prescribed for patients is advised especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g alcoholics, former addicts and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months dosage should be reduced gradually rather than abruptly stopped since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia or visual disturbance occur, the dose should be reduced If symptoms continue patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma shock vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure pulse and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g caffeine Metrazol or amphetamine may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but as a rule this disappears as therapy is continued Should drowsiness persist and be associated with ataxia this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses peripheral edema and fever have also been reported

More severe cases, observed only very rarely may also have other allergic responses, including fever fainting spells angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura agranulocytosis and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

Copyright © 1981, Wyeth Laboratories
All rights reserved

*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101

TM

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Asghar Afsari, MD OBG
7419 Middlebelt #1
West Bloomfield, 48033

Harry Applebaum, MD PDS/GS
Henry Ford Hosp.
Detroit, 48202

Frederick Aptowitz, MD P
14592 Northline #2
Southgate, 48195

David O. Bankole, MD IM/ON
25350 M. Drive North
Albion, 49224

Donald H. Batts, MD IM
S.W.M.H.E.C.
252 E. Lovell St.
Kalamazoo, 49007

Vicki C. Beshlian, MD PS
4658 Lamplight Lane, SE #H-23
Grand Rapids, 49506

Youl Choi, MD OBG
10957 Farmington Rd.
Livonia, 48150

Leslie R. Cohen, MD DR/R
2710 W. Court Street #12
Flint, 48503

Paul C. Colligan, MD CLP
1000 Houghton
Saginaw, 48602

Jagdish Sodashive Dave, MD PTH
5 Research Drive
Ann Arbor, 48103

Carl F. Eiben, MD PM
1904 Como Ave., SE
Minneapolis, MN 55414

Michael S. Eichenhorn, MD IM/PUD
Henry Ford Hosp.
Detroit, 48202

Larry G. Goss, MD FP
417 W. Monroe St.
Bangor, 49013

H. Barton Grossman, MD U
C5111, U of M Med. Ctr.
Ann Arbor, 48109

Neil E. Grossnickle, MD GP
Sand Point Rd.
Munising, 49862

Richard I. Haddy, MD FP/ID
7432 Creekside Dr. #12
Lansing, 48917

Linda S. Hotchkiss, MD P
953 Lakepointe
Grosse Pointe Park, 48230

J. Christopher Hough, MD FP
4005 Orchard Drive
Midland, 48640

Douglas R. Jackson, MD ORS
1414 W. Wackerly Rd.
Midland, 48640

Kevin J. Kelly, MD IM
1517 S. Park St.
Kalamazoo, 49001

Jeannie J. Kinzie, MD TR
436 Lakeland
Grosse Pte., 48230

Michael D. Klein, MD PDS/GS
U of M Med. Ctr., F7516, Box 66
Ann Arbor, 48109

Robert P. Kobiela, MD IM
3504 Collingwood, SW
Grand Rapids, 49509

Kurt J. Koepnick, MD IM
740 Winchell, SE
Grand Rapids, 49503

Alan S. Lachniet, MD ORS
1675 Leahy St.
Muskegon, 49442

Edwin R. Larkin, MD OPH
528 Beech St.
Charlotte, 48813

James E. LeMire, MD FP
1197 Heather Dr.
Holland, 49423

David H. Looff, MD P/CHP
6850 S. Division Ave.
Grand Rapids, 49508

William C. Loop, MD IM
295 N. Maple A
Tawas City, 48763

Peter B. Lundeen, MD
1275 Colrain, SW
Wyoming, 49509

William Maliszewski, MD PD
11885 E. 12 Mile Rd.
Warren, 48093

Lawrence J. Marentette, MD OTO
14 Belleview
Mt. Clemens, 48043

Mohammad Mohsenian, MD OBG
One Hurley Plaza
Flint, 48502

Scott P. Monson, MD ORS
5991 Guilford
Detroit, 48224

Jalal G. Najem, MD GS
2765 Flushing Rd.
Flint, 48504

Richard C. Nielsen, MD IM
P.O. Box 222
Benzonia, 49616

Larry L. Pack, MD ORS
G-5057 W. Bristol Road
Flint, 48507

Donald B. Passal, MD PD
1000 Houghton
Saginaw, 48602

Ronald D. Pelavin, MD IM
29255 Northwestern Hwy. #201
Southfield, 48034

Abdul M. Quazi, MD GS
33155 Annapolis
Wayne, 48184

Harry H. Rozencweig, MD IM
29255 Northwestern Hwy. #201
Southfield, 48034

Krishna K. Sawhney, MD GS
24555 Haig
Taylor, 48180

Sharon M. Schafer, MD AN
5741 Folkstone
Troy, 48098

Paul E. Schreiber, MD GS/CDS
1717 Shaffer St. #107
Kalamazoo, 49001

Mark M. Segall, MD CRS/GS
18161 W. 13 Mile Rd. E-1
Southfield, 48076

Devendra K. Sharma, MD FP
541 Lake St.
Tawas City, 48763

NEW MEMBERS/*continued*

Harbhajan Singh, MD AN
11800 12 Mile Rd.
Warren, 48093

Thomas L. Slovis, MD PDR/PD
3901 Beaubien
Detroit, 48201

William Solomon, MD IM
29255 Northwestern Hwy. #201
Southfield, 48034

Carol Sue Southland, MD EM/FP
1742 Hubert Rte. 9
Midland, 48640

Tommy S. Stevens, MD FP
6055 Blvd. of Corners Four #3
Grand Blanc, 48439

Mark G. Swedenburg, MD GP
USAF Hospital Kunson, Box 86
APO S.F. 96264

Robert A. Teitge, MD ORS
Henry Ford Hosp.
Detroit, 48202

Marilyn R. Terranella, MD IM
1718 Grove
Kalamazoo, 49007

John H. Triebwasser, MD IM/CD
4922 Sturgeon Creek Pkwy.
Midland, 48640

Gray L. Trock, MD PD/PN
755 W. Big Beaver Rd.
Troy, 48084

Fred J. Van Alstine, MD FP
775 S. Main St.
Chelsea, 48118

William L. Vander Vliet, MD FP
413 Mecosta Ave.
Big Rapids, 49307

Karl S. Wagner, MD OBG
219 Shagback Dr.
Rochester, 48063

James A. Webley, MD EM
7631 Kingsbridge
Canton, 48187

Thomas F. Winters, MD FP
616½ Kellogg, SE
Grand Rapids, 49503

Begum Zubeida, MD GPM/OBG
45760 Concor
Plymouth, 48170

EMERGENCY MEDICINE FOUNDATION

A gift to the Emergency Medicine Foundation in tribute to someone you wish to honor will advance research and education in emergency medicine. Your thoughtfulness will be appropriately acknowledged.

EMERGENCY MEDICINE
FOUNDATION
3900 Capital City Blvd
Lansing, Michigan 48906

MICHIGAN STATE MEDICAL SOCIETY

PHYSICIAN SERVICE GROUP

MSMS's member service subsidiary offers assistance in:

Practice management
Financial planning
Computer usage

Created by MSMS to provide quality financial services to Michigan physicians.

We can show you how to save thousands of dollars by making your practice more efficient, and allowing you to spend more time practicing medicine and less time practicing business.

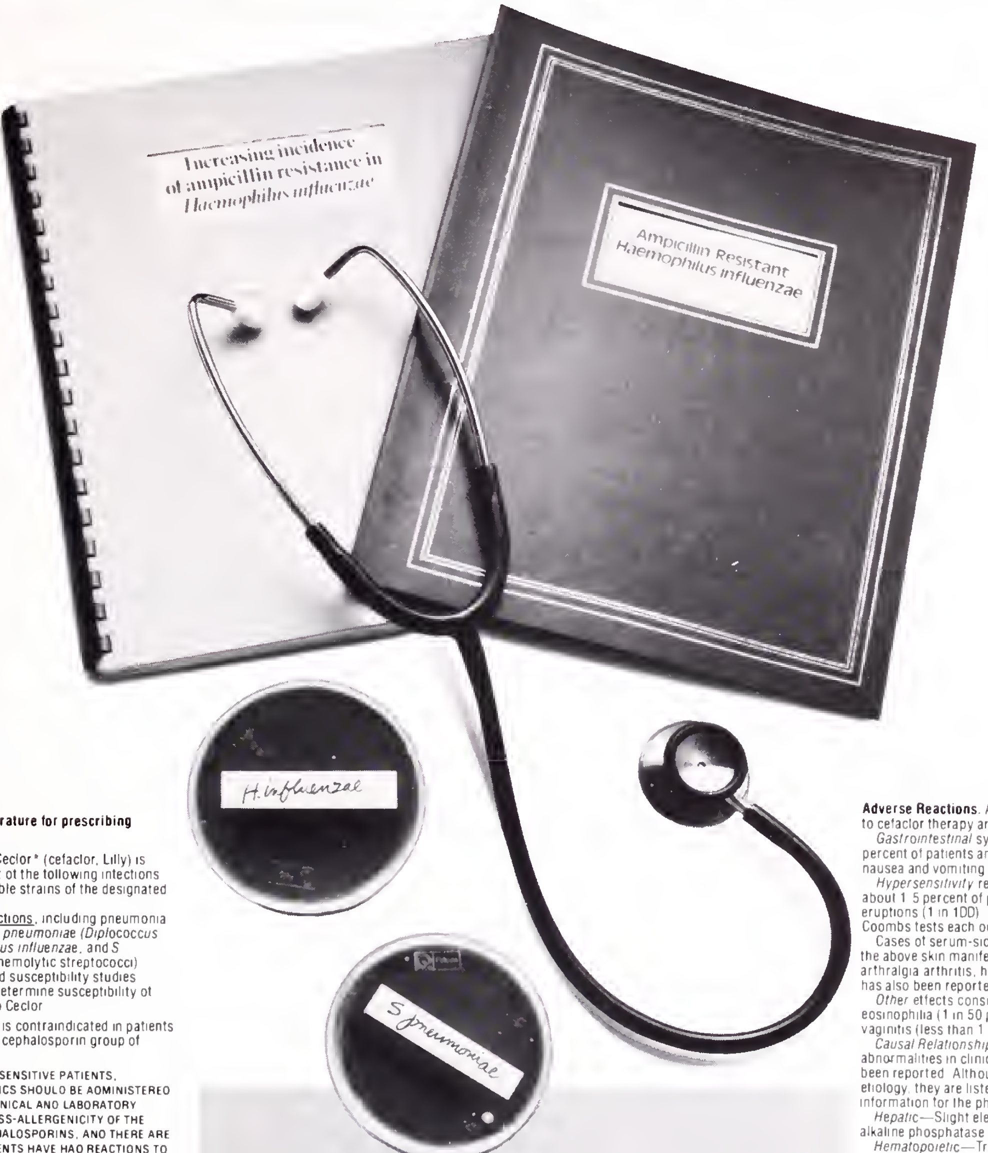
For specific information on how to take advantage of the above services and many others, contact:

John Anthony
General Manager

At: **Michigan State Medical Society: 517/337-1351**

Or write: **Physician Service Group, Inc.**
1305 Abbott Rd.
East Lansing, MI 48823

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions. Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [103080R]

---

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* [8]

Note Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

1 Antimicrob Agents Chemother , *8* 91, 1975
2 Antimicrob Agents Chemother , *11* 470, 1977
3 Antimicrob Agents Chemother , *13* 584, 1978
4 Antimicrob Agents Chemother , *12* 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880 Washington, D C American Society for Microbiology 1978
6 Antimicrob Agents Chemother , *13* 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr , and J E Bennett), p 487 New York John Wiley & Sons, 1979

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina Puerto Rico 00630

100061

VIEWS

Psychiatrists seek colleagues' aid in maintaining privacy of records

By Douglas A. Sargent, MD, Grosse Pointe Farms

Recently an old problem has taken on a new significance for psychiatrists: fresh assaults on the privacy of the medical record are making it difficult for us to keep our patients' confidences.

Although this arises in our part of the forest, we think the problem is of general concern to medicine, would like to share it, and recruit help of our colleagues in maintaining our tradition of medical privacy.

Psychiatrists know that if our patients are to benefit from our ministrations they must feel free to confide in us their deepest, sometimes darkest, secrets. Such confidences are only given in the expectation that we will guard them against unpermitted disclosures. In most states this expectation has been enacted into statute; of course, it also lies at the root of the doctor-patient relationship and Ethical Canon #9 urges us to protect our patients' expectations of privacy.

Growing pressure

Yet we know that all of medicine is under growing pressure to open patients' records to scrutiny by third parties such as insurance carriers, law enforcement and other governmental agencies, and employers, each claiming a "need to know." Often we are assured that our patients do not need to know that their medical records have been exposed to these prying eyes.

The practice of psychiatry cannot exist in an atmosphere devoid of privacy. Privacy is our "sterile technique," as necessary to our practice as a germ-free operative field is to the surgeon. Honesty requires us to insist upon the genuine article, and not accept the mere appearance of privacy.

Some would urge upon us that a persuasive simulacrum is good enough to satisfy our patients so long as they don't find out that their secrets are not safe in our hands. But how could we insist that our patients "tell all" while we withhold the fact that we cannot guarantee privacy? Nor does a *pro forma* "surgeon general's warning" that confiding in us might not be safe suffice if we then vitiate the effect of the warning, lulling our patients into a false sense of security by accepting their secrets as if we could keep them.

Our dilemma should be explained to legislators so that they can comprehend our reluctance to open medical records to all who wish to see them. The expectation that physicians should be trustworthy is deeply ingrained in our tradition. Surely most lawmakers know this and would want their own physicians to be worthy of their trust.

In balancing the patient's privacy rights against the needs of third parties to guard against fraud or abuses, the courts have told us that privacy rights are paramount. Since the physician is in the best position to know how his patients' rights are endangered, it is our duty to do what we can to protect them.

Legislative loopholes

Little publicity is given to the loopholes in proposed "privacy legislation" which give law enforcement and health agencies almost unrestrained access to medical records. Few of our patients are aware of the extent to which insurers and employers share information gleaned from medical records, nor of the burgeoning data banks that store health information and regurgitate it almost on demand. Few patients know how their job security may be jeopardized by "facts" spit out by computers, facts that they never have the opportunity to challenge.

One especially flagrant abuse was described in *New Approaches*, the report of the National Commission on Confidentiality of Health Records in June, 1979: a county prosecutor in a Western State wanted the records of all Indian minors who were pregnant in order to find their paramours and prosecute them for statutory rape. Other, similarly outrageous abuses are detailed in this publication. The Krever Commission in Ontario uncovered widespread use of private detectives by insurance companies who stole information from health records in order to blackmail patients into unfavorable settlements of insurance claims. We have no reason to assure ourselves that "it can't happen here."

Unaware of these depredations, our patients expect us to honor our ethical obligation and protect their privacy, not recognizing that our best effort to do so may be vitiated by forces that are beyond the ability of individual physicians to control.

Shall we tell them and run the risk that they will refuse treatment? I think that we should, and at the same time resist incursions into the privacy of the record while there is still something left to protect.

Doctor Sargent is immediate past president of the Michigan Psychiatric Society.

works well in your office . . .

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.
- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.

(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Computers: Tools for cost-effective management

By Jeffrey Rich, special to Michigan Medicine

A computer software salesman recently said that it would take about one trillion human beings to do the work currently performed by computers. However erroneous that estimate, it is a certainty that computers are at work everywhere. And, as the design of data processing systems improves, their applications broaden, weaving automation deeper into our social fabric.

The medical community, faced with quantum leaps in information, increasing patient loads, billings, forms, and procedures, is being called to the task of proving itself cost-effective. A well-conceived computer system can be an immeasurable aid to cost-reductive management.

But this destined marriage of medicine and computers is marking physicians as prime targets for salesmen eager to automate office management systems across the land. And just as this developing technology can offer great inroads to more efficient medical budgeting, a poor choice in systems can prove to be a costly, time-consuming disaster.

Blueprint for action

The intent of this article is to provide physicians with a blueprint for action when they decide whether or not to automate, and what to look for if they do.

With 10 years' experience in physician office management consulting, John H. Anthony of MSMS Physician Service Group (PSG), has witnessed the application of computers to many clinical settings. He feels they are affordable, readily available, suited to physicians' needs, and understandable enough to be used, despite the lack of user expertise. Evaluating and choosing the proper system, however, requires the assistance of experts, he says.

A physician under the impression that a person can go to a store, compare a couple computers, bargain a little, bring one home and plug it in, grossly underestimates the complexity of choosing a system. It will require an investment of time and effort as well as money. Consider the following issues:

There are no magic wands that can transform a fundamentally-poor manual system to a smooth-running automated one. Computers operate within an orderly environment. As the quality of data recovered depends on the value of that put in, the management system must be organized before the pleasures of automation can be enjoyed. In many cases, straightening out a tangled system will eliminate the need for the computer.

An important component in the well-designed system is a trained and motivated staff. Staff is that element that either uses or abuses the tools: hardware, the term given to the computer and related equipment comprising the data processing system; and software, the program of information storage and retrieval into that equipment.

The physician must be thoroughly versed in all facets of operation of the system to hope to use it to its potential. The more highly-trained the staff, the greater level of productivity a computer can reach.

There are no established guidelines to determine who should automate or at what point automation becomes a viable investment. A psychiatrist seeing 30 patients a week does not have the scheduling, bookkeeping, or external reporting requirements as does the clinic seeing 300. Financial factors influencing this decision, as recommended in the AMA Special Report on Computers and Medicine, are: patient volume and demographics, physician and staff turnover; geographic locale, overhead or administrative expenses relative to total income, the number of specialties involved, and ancillary services provided by the clinic.

In-depth assessment

An initial step towards automating is an in-depth needs assessment of the current manual system, covering two general areas: 1) evaluation of present system, and 2) ability to automate. Many physicians retain the services of a consultant who specializes in such areas.

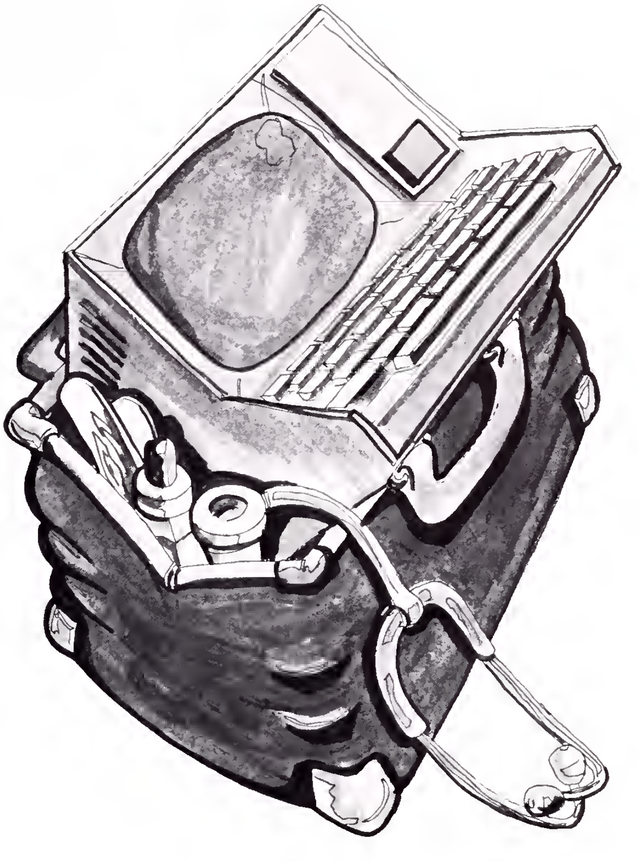
A qualified consultant can identify the strengths and weaknesses of the office management system. By observing such things as paper flow, staff responsibilities, patient volume, general accounting, inventory control, and scheduling, a profile of the practice can be developed.

In cases where the manual system has been ineffective, it may be possible to isolate the weak link in the office chain. The perceptive consultant will take note of problems like wasted staff time, duplicate efforts, rate of error in external reporting, poor capture in billing services rendered or in-hospital activities, ineffective statements, or excessive files of aged receivables.

The next step is to define the desired characteristics for the ideal management system. In light of the assessment, tangible goals can be set for the practice.

After doing the needs assessment, the physician and consultant should draw up a list of alternatives to arrive at the "ideal system." Some alternatives may be to expand the manual system staff, rent time with a computer service bureau, or purchase a computer.

The next step is to figure a cost benefit ratio for each of the alterna-



tives, as you analyze their impact on your practice. One option is to reject all of the proposed systems and keep the present one. The best decision may also be to use a service bureau, until the volume of patients reaches a certain point; then invest in a computer.

There are many horror stories of exorbitant price tags for computer systems that did not do what the physician thought they would. "These are usually due to a breakdown in the pre-implementation process," says Joe LaVoie, Data Processing Manager for Michigan Physicians Mutual Liability Company. With 15 years of computer systems design and implementation, 10 of them in medical computers, he has found that most problems are not with the hardware or software, but with the planning that took place before the equipment was installed.

Communication key

The quality of communication between consultant, physician and staff is a key to the selection and design of an effective system choice. The doctor should not underestimate the importance of the observations from the clerk who performs the daily office functions. That is the person who has the most contact with the system, and can tell where things get fouled up.

With wise planning, the system will be capable of smooth adaption to changes in the volume or variety of functions it is expected to perform. Upgrading hardware and/or software should be a pre-conceived option, particularly with the rapid development of new technology and applications. Some systems bought five years ago already are obsolete. This is something to consider when shopping for a company to deal with: where will they be in 10 years?

Be alert to the danger of underestimating the total cost of implementing an automated system. Vincent Gebes, director, Management Team, Inc., Lansing, warns that the final cost may be as much as 60 percent more than the price ticket on the hardware, after software and consultation fees are figured. All costs can be determined in advance, when a physician still has the option not to purchase.

In the haste and excitement of obtaining a new computer, many physicians later find they have overestimated the capability of their new system. Perhaps the software does not fully meet external reporting or internal auditing needs, or the hardware itself does not fit in the office environment. Information retrieval may be slower than anticipated, or memory capacity insufficient. A guarantee against this is a written statement specifying exactly what the computer system is to do. The vendor should provide this document, to compare it with the physician's concept of the "ideal system." If after the system is operational, the computer does not perform a function envisioned and paid for, there is proof of contract violation.

You don't convert a manual system to a mechanized form of data processing overnight. Edward J. Beranek of Beranek and Associates, Illinois, says the "study, preliminary design, and selection could take anywhere from one to 12 months, depending on the complexity of the practice, availability of the physicians, their staff, and any vendor input necessary."

In a well-conceived computer system, the benefits are many, ranging from the business application, to improving patient care, to enriching physician information resources.

Perhaps the most exciting and unexplored benefit is the capacity to perform in-house research and review.

If managed in an orderly, patient manner, investment in a computer system can result in less wasteful, more efficient office management with vast potential for future innovation.

Rep. Jean Willoughby's new job one of her hardest ever

By Willah Weddon, special to Michigan Medicine

Rep. Willoughby

"I can't wave a magic wand, but I can be instrumental and effective here in the legislature," says State Representative L. Jean Willoughby. She adds, typically, "I intend to be . . . you better believe, I intend to be."

She is the first member of the MSMS Auxiliary to serve in the State House and the first woman to be seated from Oakland County's 62nd District.

Furthermore, last fall was the first time she'd sought an elective office. She ran against an incumbent of eight years in a district that had been a Democratic stronghold for as long as she can remember.

A registered nurse, she is married to William A. Willoughby, MD, Bloomfield Hills ophthalmologist (who also has an office in Wayne County).

Rep. Willoughby has been appointed to committees of primary interest to her constituents: Economic Development and Energy, Urban Affairs, Civil Rights, and Consumers.

No labels

"I march to my own drummer. You can't pin labels on people," she said. But she describes herself as "fiscally conservative" and agrees with President Ronald Reagan's philosophy.

"We have many problems, but I think improving the economic climate in Michigan and getting people back to work will help solve these," she contends. "When people have jobs it increases revenues to the state and cuts down on the welfare roll expense."

Much of the freshman lawmaker's time during the past seven years has been spent in school. At age 47 she entered the University of Detroit where she earned a Bachelor of Arts degree in communications in 1976. During this time she served a year on Wayne County Medical Society Auxiliary's board, doing press relations work. (Today she's a member of the Oakland County Auxiliary.)

Then she began a student internship for former State Representative Mel Larsen (presently chairman, Republican State Committee) and her interest in government grew as she proceeded to obtain her MS degree in political science in 1979. During these years she became increasingly convinced most legislation being enacted was not in tune with the thinking of the majority of the people.

"I felt it was time the average individual's opinion was heard," she recalls. "So I decided to run for office."

When asked if she had thought she could win, Rep. Willoughby replied with a laugh, "Yes, but I was about the only one. Another woman thought so, — Peg Goldsmith in Pontiac — and she became my campaign manager. We formed an exclusive club."

"We moved around a lot, making it look like we had a big staff," she recalls. "I knocked on 17,000 doors in my district." About three months before the November election, others began to think she might be a winner, and a little more financial help trickled in.

"I've been told my campaign cost less than any other to unseat an incumbent," she said. "We spent between $20,000 to $22,000." Her victory was considered an "upset" and her opponent demanded a recount. But Rep. Willoughby had learned something experienced politicians know — it's the votes that count — and she had them.

Tough job

Rep. Willoughby admits this new job is one of the hardest she's ever had. This includes the years when she had four children under the age of four. Two more followed, three years apart.

"You have to be here early in the morning for committee meetings, talk to people, locate and digest information and then attend legislative sessions," she says. "There isn't a night I don't carry home a briefcase full of material. And I'm busier during the days at home, if possible, tending to other aspects of a representative's job." But she obviously thrives on it.

As for Doctor Willoughby, he's always been interested and well versed in politics, but too busy to be actively involved. "He usually comes up on Wednesdays and we have dinner here," she said with a smile.

"He tends to stop people on the street and tell them I'm a Representative. He and the children (all grown and away from home) are so proud, it's almost embarrassing."

This article is part of a continuing series of profiles of legislators whose work influences medicine in Michigan.

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN

Healthy Competition Makes A Healthier Market

**Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.**

Occurrence Coverage

Choice of limits — $100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

NEWS

By Bonnie L. Groff, MSMS staff

Maurice S. Reizen, MD, Lansing, right, is recipient of an MSMS presidential citation award for state health planning efforts. The award was presented at the MSMS House of Delegates meeting in May. He is photographed above with AMA Trustee John J. Coury, Jr., MD, Port Huron.

Maurice S. Reizen, MD, Lansing, is recipient of the esteemed, national Arthur T. McCormack Award of the Association of State and Territorial Health Officials. The association includes health officials from all 50 states and U.S. territories. Each year one state health official is singled out as "a leader in our society who cares deeply for all." . . . **Charles C. Vincent, MD,** Detroit, has been named Distinguished Alumnus of the Wayne State University School of Medicine. . . . **Vainutis K. Vaitkevicius, MD,** Pleasant Ridge, is this year's recipient of the Lawrence M. Weiner Award, given by the Wayne State University Medical Alumni Association. The award honors outstanding contributions by a non-alumnus to the School of Medicine. . . . **Doctor Vaitkevicius** has also been named the first recipient of the American Cancer Society's annual "life award." The special citation was initiated by the American Cancer Society to recognize medical professionals in the metropolitan Detroit area who have dedicated themselves to improving the quality of survival for persons afflicted with cancer. . . . **Judith E. Tintinalli, MD,** Detroit, has been awarded the James A. Mills, MD, Award for meritorious service to emergency medicine by the American College of Emergency Physicians. Doctor Tintinalli was cited for two major endeavors. She was editor of *A Study Guide in Emergency Medicine*, a major text published by ACEP, and, she is chairman of the Liaison Residency Endorsement Committee, which is charged with the responsibility of reviewing residency programs in emergency medicine. . . . **Anna H. Broecker, MD,** Grand Rapids, was re-elected president of the Kent Medical Foundation. Her new term will run for three years. . . . **Robert Williams, MD,** Harbor Springs, is the new president of the Michigan Chapter of the American College of Emergency Physicians. . . . The Wayne State University Association for Emergency Medicine has given its annual award for the best 1980 paper to **Blaine C. White, MD,** Detroit. Doctor White won the award for his work entitled "Mitochondrial O_2 Use and ATP Synthesis: Kinetic Effects of Ca^{++} and HPO_4^{-2} Modulated by Glucocorticoids." . . . Five Providence Hospital physicians who have served on the hospitals' medical staff for a total of over 150 years were honored at the fourth annual Friends of Providence dinner in early April. The doctors, who received special awards for their distinguished service to the hospital included: **Frank Duwe, MD; James Fryfogle, MD; Bruce Lemon, MD; Kenneth Trader, MD,** and **Joseph Watts, MD.** . . . **Donald J. Jaffar, MD,** and his wife, Dorothy, of Southfield, have established the first fully endowed chair at Wayne State University. Their donation to the Department of Urology in the School of Medicine will fund the salary of the chairman as well as funding a new research professor. . . . **Joseph C. Cerny, MD,** Detroit, has been elected to the Board of Trustees of the National Kidney Foundation of Michigan. . . . New president of the Michigan Thoracic Society is **Paul A. Kvale, MD,** Detroit. . . . **Richard D. Nichols, MD,** Detroit, is new president of the Walter P. Work Society. . . . The March 27 issue of *American Medical News* contains a feature on the Detroit Medical Society. The article quotes **George A. Lightbourn, MD,** president, and **John A. Feemster, MD,** vice president, on how DMS has addressed the particular problems of black physicians, black professionals, and black patients. . . . **Samuel J. Nichamin, MD,** Detroit, is a contributing editor to a new monograph published by Dorsey Laboratories, Lincoln, Nebraska. "Perspectives in Drowsiness: Important Considerations" defines in detail the types and etiology of drowsiness and suggests considerations for physicians, particularly those prescribing medications. . . . **Paul Werner, MD,** Gladstone, has moved to Macon, GA, to take a new position as director of curriculum for undergraduate programs at Mercer University School of Medicine. Doctor Werner will be director for the first three undergraduate years and his responsibilities will be to direct, design and implement the curriculum. . . . New vice president of the Society of American Gastrointestinal Endoscopic Surgeons is **Thomas L. Dent, MD,** Ann Arbor. This national society of surgeons was recently formed to promote the highest standard of academic and clinical achievement in the field of gastrointestinal surgical endoscopy.

Put us to the test.

Send us a split specimen—at our expense—we'll prove our accuracy.

First, establish an account with us. It won't cost you anything. Then at your convenience, draw a specimen using accepted procedures. Divide it and submit it under two names. When you receive the results, and you're satisfied they're statistically parallel, call us. We'll credit your account. It's that simple.

What else can you expect?

Quick results. We have three strategically located labs to provide routine test results within 24 hours, tissue results within 48 hours. Plus STAT service on some procedures.

Pickup and mail service. In many areas, our trained couriers will pick up your specimens. Outside our wide service areas, we provide prepaid mailing containers.

Quick-scan highlighted reports. Our reports were designed by pathologists. Abnormals are highlighted, making them easy to spot.

Staff pathologists. Abnormals are reviewed daily by our full-time staff pathologists. Any significant abnormal is immediately retested at no charge and the confirmed results phoned to you. Of course, our pathologists are available for consultation at any time.

Serum retention program. To make it easier for both you and your patient, every serum specimen is frozen for one week after initial testing. If further testing is necessary, just call us.

Accuracy assistance. We can assist you in training your personnel in laboratory procedures and proper specimen handling. Proper collection, handling and submission at your end further ensures accuracy at ours.

We're CBC and we've got a lot more to offer you. Our service is comprehensive, convenient, fast, and most important . . . accurate. Take the time to take our test. It may be one of the best things you ever do for your patients. And we *can* prove it.

To put us to the test call:
1-800-632-0706.

CBC CONTINENTAL
BIO-CLINICAL
LABORATORY SERVICE, INC.
Grand Rapids, Michigan • Toledo, Ohio
Mishawaka, Indiana

MEDICO-LEGAL

Gulag Livonia

By A. Stewart Kerr, Detroit

This is the interesting saga of Frank N. Bredau, Jr., MD, a physician on staff at St. Mary's Hospital, Livonia.

One night in 1980 when he was on duty at St. Mary's Hospital, a police officer came in the emergency room and asked Doctor Bredau, pursuant to a search warrant, to draw blood to ascertain the alcohol content of a suspect in a negligent homicide case.

Doctor Bredau refused to do so because he had never seen the man, did not have the man's consent to the procedure, had no knowledge of any previous treatment and had not had the benefit of an examination.

The policeman, fearful the suspect would sober up, obtained an Order to Appear from Livonia District Judge McCann, who was dining nearby, directing Doctor Bredau to draw the blood. Doctor Bredau again refused.

He was taken before the court at night, pursuant to a warrant for his arrest for contempt. At the court, Doctor Bredau repeated his reasons to Judge McCann and refused to perform the service. After refusing to post a bond, he was slapped into the local jail, fingerprinted, relieved of his belt and shoelaces, and held for 12 hours. He eventually was released after the blood sample was taken by some other physician.

Subsequently, Doctor Bredau was convicted of violating a Livonia ordinance:

> "It shall be unlawful to resist any police officer . . . while in the discharge or apparent discharge of his duty, or in any way interfere with or hinder him in the discharge of his duty."

There is a comparable Michigan statute of statewide import but the Livonia ordinance does not track it faithfully.

On appeal, the Wayne County Circuit Court stated that passive conduct (failure to assist) is without the ambit of the ordinance; Doctor Bredau merely failed to assist the officer pursuant to the court order. This was not a resistance, interference or hindrance. The Wayne County Circuit Court said that the Livonia ordinance does not impose a duty to assist. Accordingly, the Wayne County Circuit Court reversed Doctor Bredau's conviction.

Incredibly, the city of Livonia is seeking the appellate court's permission to appeal. MSMS is reliably informed that Livonia now fears Doctor Bredau will sue for damages — which could be aggravated by such appeal.

MSMS gave financial support to the Wayne circuit court proceedings because of the statewide implications of the ruling to all Michigan physicians. Let us hope that Doctor Bredau also prevails in the Court of Appeals.

Mr. Kerr is MSMS legal counsel.

These Michigan cases summarized by AMA in CITATION newsletter

"MD's Divorce Payments Increased On Appeal," Michigan Court of Appeals, Feb. 8, 1980, from the *Citation*, Vol. 42, No. 7.

"Physician Sued For Cancer Patient's Death," Michigan Court of Appeals, June 3, 1980, from the *Citation*, Vol. 42, No. 8.

"Hospital Not Liable To Security Guard," Michigan Court of Appeals, April 22, 1980, from the *Citation*, Vol. 42, No. 8.

"Physician Not Negligent In Treating Fracture," Michigan Court of Appeals, June 16, 1980, from the *Citation*, Vol. 42, No. 9.

"DES Daughter's Suit Barred By Time Limits," Michigan Court of Appeals, June 2, 1980, from the *Citation*, Vol. 42, No. 9.

"Arbitration Agreement Upheld By Michigan Court," Michigan Court of Appeals, July 23, 1980, from the *Citation*, Vol. 42, No. 12.

Medical support for hemophiliacs

Medical support services are available for hemophilia care from the Hemophilia Foundation of Michigan.

The foundation offers a network of coordinated services as a resource for health care professionals, including: medical and diagnostic evaluation, laboratory testing, orthopedic and physical therapy evaluation, dental evaluation, nursing evaluation, and comprehensive treatment planning.

Physicians may receive advice and consultation for emergency care and general inquiries by calling (313) 973-0305.

Five diagnostic and treatment centers in Michigan offer a total team service to hemophiliacs and their families. Clinics receive support from the US Department of Health and Human Services. They are University of Michigan Hospital, Ann Arbor; Children's Hospital of Michigan, Detroit; Bronson Methodist Hospital, Kalamazoo; Michigan State University, East Lansing; and William Beaumont Hospital, Royal Oak.

In addition, annual comprehensive field clinics are held in Traverse City, Marquette, Grand Rapids and Flint to provide comprehensive services for patients in their local community.

For more information, call or write the Hemophilia Foundation of Michigan, an agency of the United Way of Michigan, 2301 Platt Road, Ann Arbor, Michigan 48104.

Michigan Board of Medicine disciplinary actions

January 7 to April 8, 1981

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized.

- **Robert Elmer Grunawalt, MD**

1500 Weiss Street
Saginaw, 48602

Date, Action Taken
January 7, 1981
Limited License while on Probation from 1-23-81 to 1-23-83

Violation
Prescribing, obtaining and possessing a schedule II controlled substance.

Prescribing a schedule II controlled substance.

- **Robert Hamilton White, MD**

384 Hamilton Avenue
Birmingham, 48011

Date, Action Taken
January 9, 1981
Licensee placed on Limited License from 2-7-81 to 2-7-82

Violation
Incompetence.

Prescribing drugs for other than lawful therapeutic purposes.

- **Boleslaw Krawczyk, MD**

117 Ambler Road
Lake Columbia
Brooklyn, 49230

Date, Action Taken
March 18, 1981
Summarily Suspended from 4-2-80 to 5-18-81
Revoked effective 5-18-81

Violation
Engaged in conduct which impaired his ability to safely and skillfully practice.

Engaged in substance abuse.

Suffered from a physical inability reasonably related to and adversely affecting his ability to practice in a safe and competent manner.

- **Charles H. McManus, MD**

921 Webster Street
Traverse City, 49684

Date, Action Taken
March 18, 1981
Suspended from 3-1-81 to 4-30-81

Violation
A departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice.

Failure to use reasonable care and discrimination in the administration of drugs, and failure to employ acceptable and scientific methods in the selection of drugs or other modalities for treatment of disease.

- **Joan H. Shapiro, MD**

3168 Woodland Ridge
West Bloomfield, 48033

Date, Action Taken
April 2, 1981
Limited License from 4-3-81 to 4-3-84

Violation
Request for reinstatement of Suspended license.

U-M proceeding with construction of new University Hospital

The University of Michigan made public April 30 plans for proceeding with the construction of the new $210 million Replacement Hospital Project in October.

"This new facility, which has undergone the most rigorous public examination, is an expression of faith in the ability of Michigan to overcome its current economic difficulties," said U-M President Harold T. Shapiro. "We have been a leader in medical education for more than a century, and this project signals our determination to continue that tradition."

Shapiro said that the University was grateful for the support of Gov. William G. Milliken during the long planning process. He also noted the cooperation of the Michigan Legislature, particularly the members of the Joint Capital Outlay Subcommittee and its chairman, Rep. Gary Owen.

Financing will come from the State of Michigan, University Hospital revenues, and private philanthropic gifts.

Five U-M schools and colleges have extensive educational programs in University Hospital: the Medical School, the School of Nursing, the School of Public Health, and the School of Dentistry, and the College of Pharmacy. Each year more than 4,000 students are trained in the Hospital's clinical facilities.

The new structure will consist of a 586-bed inpatient tower upon a four-story base of diagnostic and treatment facilities. Construction, which begins in October, will be completed in 1985.

Current judicial opinions of AMA available in new booklet

Quality of life, allocation of health resources, illegal or excessive fees, confidentiality and informed consent are just part of the issues thoughtfully deliberated by the American Medical Association's Judicial Council in its new publication, *Current Opinions of the Judicial Council of the American Medical Association, 1981.*

Current Opinions relates to the revised Principles of Medical Ethics adopted by the AMA House of Delegates in 1980. *Current Opinions* "are not presented as the sole or only route to medical morality," according to the Judicial Council. *Current Opinions* supercedes all earlier publications of the Judicial Council.

Limited health care resources should be allocated efficiently and on the basis of fair, acceptable and humanitarian criteria, the Council states. Priority should be given to persons who are most likely to be treated successfully or have long term benefit. Social worth is not an appropriate criterion.

The AMA declares positively that "A physician should not charge or collect an illegal or excessive fee. For example, an illegal fee occurs when a physician accepts an assignment as full payment for services rendered to a medicare patient and then bills the patient for an additional amount."

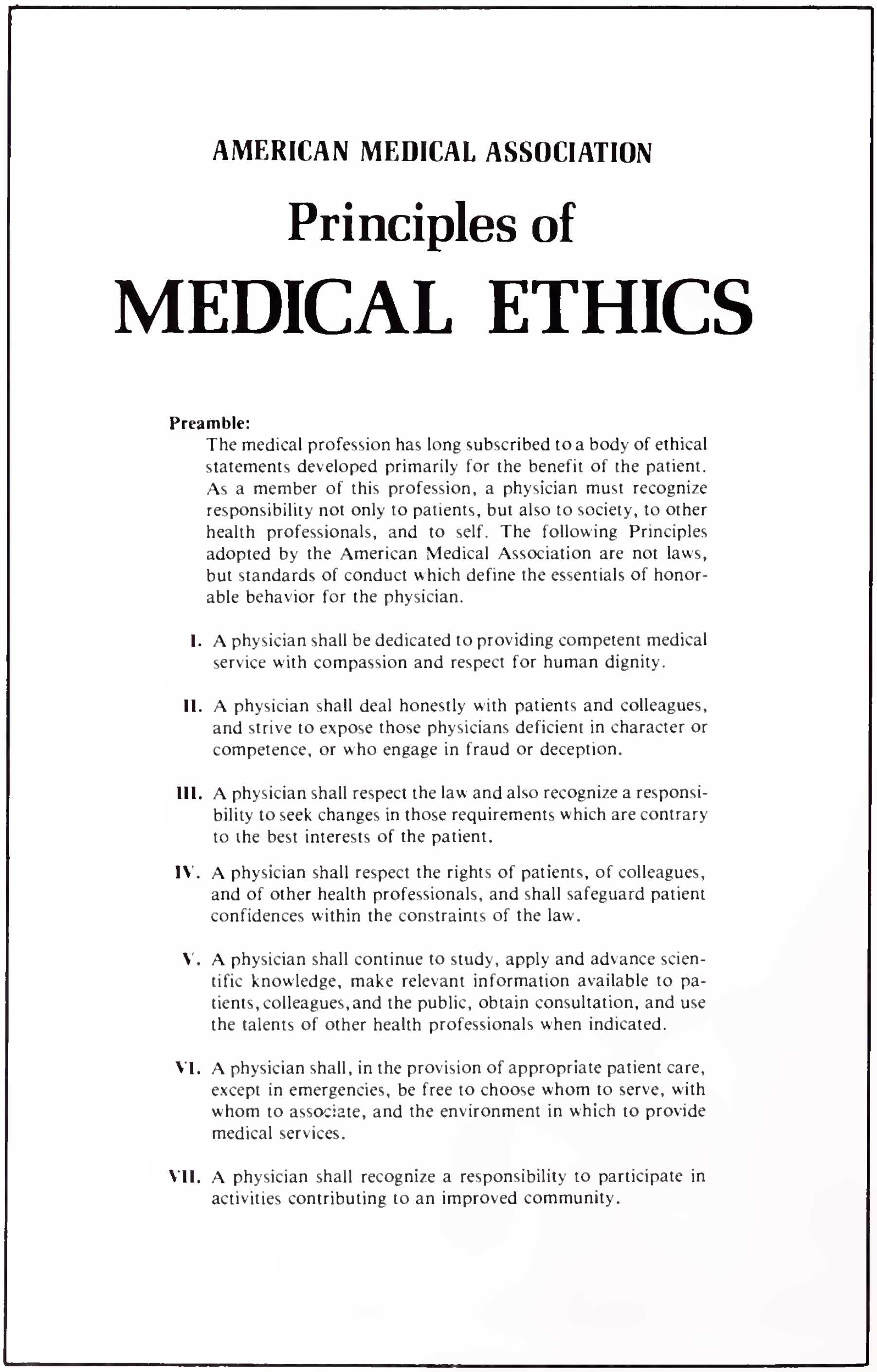
The Council states that informed consent is vital to the physician-patient relationship.

"The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment."

In caring for defective infants, the Council declares, the advice and judgment of the physician should be readily available, but the decision whether to treat a severely defective infant and exert maximal efforts to sustain life should be the choice of the parents. The parents should be told the options, expected benefits, risks and limits of any proposed care; how the potential for human relationships is affected by the infant's condition, and relevant information and answers to their questions.

In coping with terminal illness, the Council says, the social commitment of the physician is to prolong life and relieve suffering. Where the observance of one conflicts with the other, the physician, patient, and/or family of the patient have discretion to resolve the conflict.

The booklet may be purchased from: Order Department OP-122, American Medical Association, PO Box 821, Monroe, Wis. 53566. Single copies are $4.



AMERICAN MEDICAL ASSOCIATION

Principles of
MEDICAL ETHICS

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

In business communications it takes teamwork to get the job done right!

Effective business communications calls for a tightly knit team that knows communications, knows your business, and knows the importance of reaching your goals as planned and on time. At Michigan Bell we collectively call these specialists the Bell Team. There are many of them . . . each headed by an Account Executive calling the shots, experts in telephone communications and data transmission as well. And equally important, Michigan Bell Account Executives are trained and experienced in the effective application of communications equipment and systems in specific fields: insurance, automotive, banking and many others.

But no Account Executive goes it alone. He or she is backed by a team . . . a staff of industry specialists in the many communications areas . . . who can skillfully execute your plans. So why settle for less when you can call on the skills of the whole team? The Bell Team . . . people who know their business and your business.

Michigan Bell

MEDICAL NEWSFRONTS

The Leukemia Society of America, a national voluntary health agency, is now accepting applications for 1982 grants to support research in the fields of leukemia and related disorders.

Deadline for filing applications is Sept. 1, 1981. Only one application in each grant category from an individual sponsor will be considered. Project proposals will be evaluated on a competitive basis by the Society's Medical and Scientific Advisory Committee. The reviews will take place next January with funding to start July 1, 1982.

Application forms and further information may be obtained by writing to Leukemia Society of America, 800 Second Avenue, New York, 10017.

It is the physician in practice who first becomes aware of areawide chemical contamination that causes illness. The doctor learns of the chemical poisoning as he seeks to determine what is causing his patients' illness.

An early lead to possible chemical contamination as the cause of illness often comes from the sufferers themselves. The doctor must take seriously the complaint of the worker who believes something in the workplace is making him ill.

These are conclusions of the report of a workshop concerning areawide chemical contamination held at the National Academy of Sciences in Washington, D.C. The full report is now on the press. A summary appears in the April 17 *Journal of the American Medical Association.*

The experience of the Atomic Bomb Casualty Commission in studying Japanese survivors in Hiroshima and Nagasaki serves as a model for future studies of communities exposed to unusual environmental contamination, the report says.

Among case histories summarized is that of workers in Hopewell, Va., who became ill after dealing with a pesticide, Kepone. The workers not only were severely ill themselves, they wore their contaminated clothing home and many of their family members also became contaminated.

Instances of lead pollution from smelters causing lead poisoning in the surrounding neighborhood are cited in Idaho and Texas. Other dangerous chemicals were absorbed by children near copper smelters and zinc smelters.

The PBB poisoning episode in Michigan occurred when a fire-retardant chemical mistakenly was put into bags of cattle feed. Cattle sickened and died.

The widely reported Love Canal episode concerned chemicals dumped as waste into an abandoned canal. Houses bordering on the dump area became contaminated, families were relocated and the dwellings boarded up.

The Oak Ridge National Laboratory now has a Crisis Response Team that will search the scientific journals on a chemical that may be a health threat and provide summary information within 24 hours.

Most contamination problems are considered to be local and to require only practical public health control measures, the report declares. Local authorities can, if necessary, draw on state and national support resources.

Routine use of chest x-rays as a screening device before elective surgery on children should be stopped, since the procedure seldom finds conditions which result in either cancelling the operation or preventing postoperative complications, a newly published study says.

An article reporting these findings appears in the April issue of *Pediatrics*, the official journal of the American Academy of Pediatrics. Conducting the study were Robert A. Wood and Robert A. Hoekelman, MD, both of the Department of Pediatrics at the University of Rochester's School of Medicine and Dentistry, Rochester, N.Y.

The research was undertaken amidst debate resulting from concerns about the hazards and cost effectiveness of chest x-rays as a routine preoperative procedure. "Although this question has been raised for all age groups," write Wood and Doctor Hoekelman, "we have been particularly concerned about its application to pediatric patients."

These tests, they say, should be performed only on an individual case basis. Their recommendation also covers chest x-rays which often are routinely performed on children admitted to hospitals for nonsurgical reasons, and chest x-rays performed for other screening reasons, such as a prerequisite for entering college.

A machine that helps patients physically and saves them money is in use at Ingham Medical Center.

The machine is the IMC blood banks's Cell Saver, a blood salvage system. The Cell Saver collects shed blood which otherwise would be discarded, and prepares the blood so it can be returned to the patient in a transfusion.

The Cell Saver has been used at Ingham Medical since late 1979, and money saved amounted to several hundred dollars per patient.

The Cell Saver is used during open heart and aneurysm surgery, and is also used in the emergency department when a patient is hemorrhaging. The system decreases the volume of donor blood required, and relieves the demand for banked blood. During 1980, the Cell Saver salvaged more than 1,000 units of blood in 235 open heart operations.

A National Health interview survey which sampled 37,000 US households has found that children up to 16 years old living with at least one parent who smokes miss an average of 10.2 school days a year, while the children of non-smokers miss 9.1 days.

110
105
100
95
90
85

You know what you want in Step-1 antihypertensive therapy...

For your hypertensive patients,

Long-acting

Zaroxolyn® gives

(metolazone) Pennwalt

Efficacy

Start with Zaroxolyn because of its unsurpassed effectiveness in Step-1 therapy.[1-4]

Stay with Zaroxolyn because it maintains effectiveness in long-term therapy[1,5,6]...and minimizes the need for Step-2 agents.

☐ Zaroxolyn's effectiveness is maintained even in the presence of reduced kidney function[7-9]

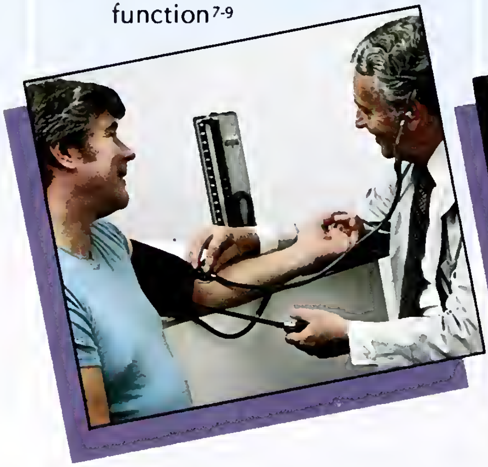
Compliance

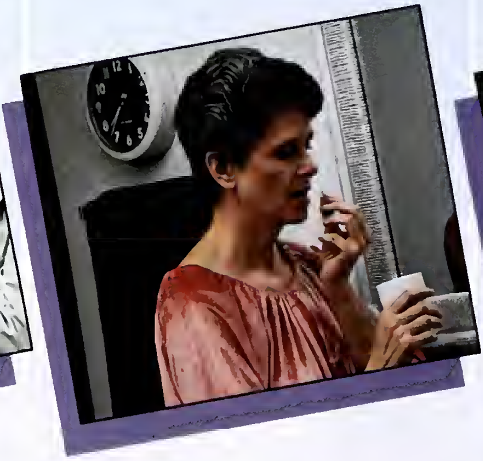
Stay with Zaroxolyn because it maintains 24-hour blood pressure control with simple once-daily dosage, and only 4% discontinue therapy due to side effects!

Safety

Stay with Zaroxolyn because clinically significant side effects are rare!

☐ Low incidence of changes in serum K+, glucose metabolism, or uric acid levels





you what you want

Compatibility

Add to Zaroxolyn easily if Step-2 agents become necessary.

- ☐ Permits lower doses of Step-2 agents to minimize side effects
- ☐ Allows flexible dosage titration, in contrast to fixed-dose combinations

Economy[10]

- ☐ Less expensive than most other diuretics
- ☐ More economical than hydrochlorothiazide in fixed-dose combination with triamterene or reserpine/hydralazine
- ☐ Costs less than beta-blockers
- ☐ Less expensive than methyldopa, clonidine, or prazosin

27
Monday
April
1981

Start with...stay with...and add to...

Long-acting

Zaroxolyn®

(metolazone)

Gives you what you want in Step-1 antihypertensive therapy

Please see following page for prescribing information.

NAME
ADDRESS
DATE
℞
Zaroxolyn
REFILL.................TIMES
NON REPETATUR ☐
Address

Long-acting

Zaroxolyn®

(metolazone) Pennwalt

2½ mg, 5 mg, 10 mg tablets

Gives you what you want in Step-1 antihypertensive therapy

☐ Unsurpassed Step-1 efficacy in mild to moderate hypertension

☐ True once-daily dosage for excellent patient compliance

☐ Positive side effect profile

☐ Strong foundation for stepped-care therapy

☐ Long-term economy

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton, 1976, pp 221-245. 3. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puschett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book 1981*, and manufacturers' suggested prices.

℞ DIVISION
PENNWALT
ROCHESTER NEW YORK 14623

A-297

Here's how Ingham County nearly halved gonorrhea incidence rate in three years

By J. Maxwell Cook, MD, MPH, Lansing

The number of cases of gonorrhea in Ingham County increased rapidly between 1970-77, reaching 2,595 cases in 1977 for an incidence rate of 940 cases per 100,000 population. This rate was the highest gonorrhea incidence rate for any county in Michigan in 1977.

The Ingham County Health Department (ICHD), with a grant from the Michigan Department of Public Health (MDPH) greatly increased its venereal disease control efforts beginning in April, 1978. The hours of the ICHD Veneral Disease Clinic were doubled, from 20 to 40 hours per week, with a corresponding increase in the number of people examined and treated. A physician is present in the venereal disease clinic at all times and assistance is provided by medical students from Michigan State University. It is the policy of the clinic to treat all sexually transmitted diseases, not only gonorrhea and syphillis. This policy is believed to promote patient confidence in the clinic, since clients are not referred for the treatment of trichomonas or nonspecific urethritis. At the time that clinic hours were expanded, one full-time staff nurse clinician was added to the existing half-time staff nurse. The number of venereal disease investigators (VDIs) was also increased from one full-time VDI to three full-time VDIs, thus permitting more intensive follow up of contacts.

The results of the changes in the ICHD Venereal Disease program are shown in **Table 1.** The actual number of cases of gonorrhea decreased from 3,595 to 1,460 and the incidence rate decreased from 963.1 per 100,000 to 536.7 per 100,000 over the three year

---

Doctor Cook is medical director of the Ingham County Health Department.

TABLE 1

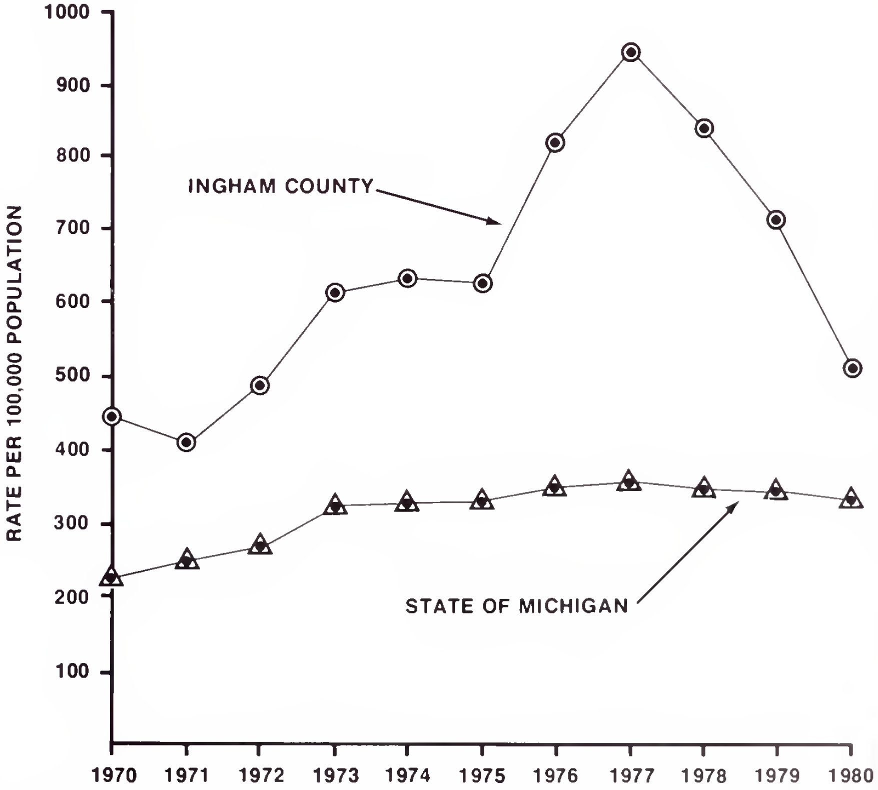
Gonorrhea incidence in Ingham County and the State of Michigan, 1970-1980

	Ingham County		Michigan	
Year	Cases	Rate*	Cases	Rate*
1970	1,169	447.8	20,359	229.4
1971	1,077	409.1	22,270	247.4
1972	1,286	484.9	24,479	274.6
1973	1,643	614.6	31,086	343.1
1974	1,759	652.6	32,067	352.5
1975	1,742	648.1	32,583	355.8
1976	2,232	833.4	34,836	382.6
1977	2,595	963.1	36,794	403.0
1978	2,384	879.0	36,647	396.9
1979	1,987	727.6	36,624	394.1
1980	1,460	536.7	35,206	380.7

* Rates are per 100,000 population.

FIGURE A

Comparison of gonorrhea incidence for Ingham County and Michigan, 1970-80



Source: Office of Vital and Health Statistics, MDPH; prepared by the Office of Community Health Assessment, Ingham County Health Department.

period 1977-1980. The incidence of gonorrhea in Ingham County is compared to that of the State of Michigan for the years 1970-1980 in **Figure A.**

In **Table 2**, the incidence rate of gonorrhea in Ingham County is compared to the rates in two similar counties (Washtenaw and Kalamazoo) and the State of Michigan as a whole for the years 1977-1980. Although the rates of incidence in these areas are lower throughout the four year period, they do not show the dramatic drop experienced in Ingham County, (see **Figure B**).

Despite popular myth, the presence of a large university — Michigan State University with its approximately 50,000 students — does not contribute to an increased number of cases of venereal disease. The number of cases of venereal disease among Michigan State University students is actually much lower than the incidence of venereal disease for the remainder of the county population.

The evidence of the Ingham County experience graphically demonstrates the effect of the application of adequate resources on a significant public health problem.

TABLE 2

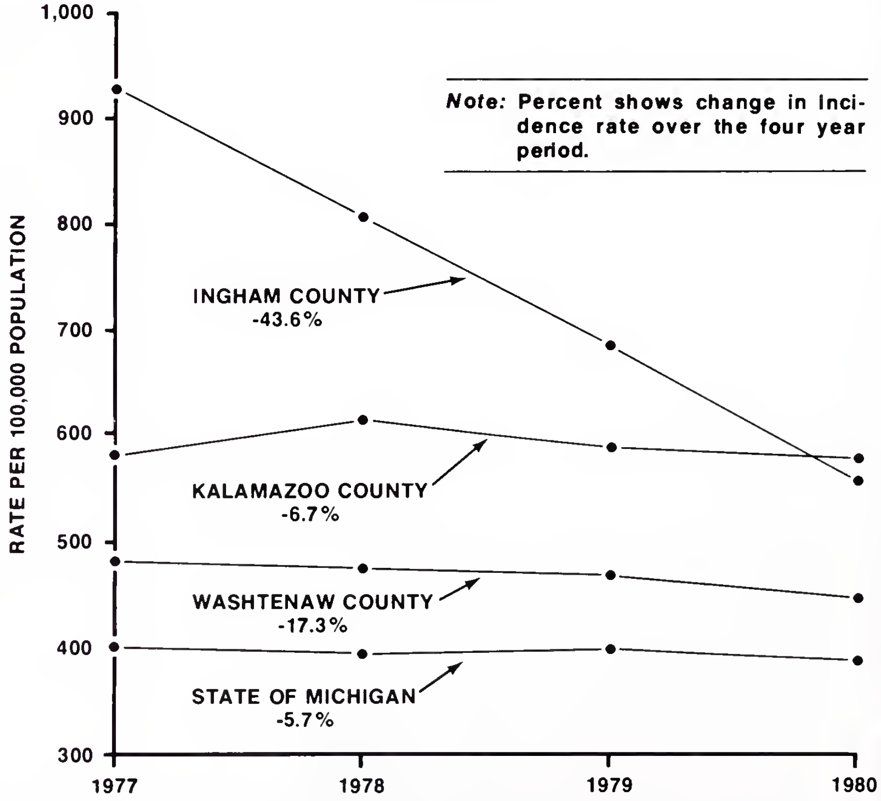
Gonorrhea incidence rates* for three Michigan counties, 1977-80

COUNTY	1977	1978	1979	1980	% CHANGE
Ingham	940.1	813.0	682.2	530.3	-43.6
Kalamazoo	586.1	614.0	573.6	546.9	- 6.7
Washtenaw	484.7	463.7	446.6	400.9	-17.3
Michigan	401.0	396.9	394.1	378.0	- 5.7

* Rates are per 100,000 population.

FIGURE B

A comparison of gonorrhea incidence for three Michigan counties, 1977-80



Source: Based on data provided by the Venereal Disease Division, MDPH. Prepared by the Office of Community Health Assessment, Ingham Co. Health Dept.

This publication is available in microform.

University Microfilms International

Please send additional information for ____________
Name ____________
Institution ____________
Street ____________
City ____________
State ________ Zip ____________

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

No One Ever Sued Dr. Kildare For Malpractice

It's true. Back in 1962 when Dr. Kildare was one of television's most popular programs, millions of Americans would have been outraged. Richard Chamberlain and Raymond Massey almost always saved the patient and solved so many unusual diagnostic problems that they were our medical heroes.

And they did it without a CT scanner, an SMA 12, and all the other sophisticated technology which fills our hospitals today. Their patients loved them. Their viewers loved them. The drama flickering across America for 60 minutes each Thursday evening reassured us that our medical care was in good hands.

But this is 1981. The Age of Consumerism, Technology, and unfortunately . . . Litigation. US NEWS & WORLD REPORT stated there were 7 million lawsuits in 1978. That's one per every 30 Americans.

We still have our medical heroes. Quincy has been sued once for malpractice and he was an expert witness in another episode. Trapper John was also sued when he rendered emergency aid away from the hospital.

Times have changed. Society has changed. Medical skills, diagnostic expertise, and physicians' knowledge have increased significantly since the days of Dr. Kildare. Yet patients are suing physicians at a frequency which is alarming to the profession.

That's why in 1975, Michigan physicians chose to control their professional liability future by forming the Michigan Physicians Mutual Liability Company (MPMLC). A company owned, controlled, and totally supported by physicians.

MPMLC is your company. It is reacting to the 1980s by providing more coverages, reducing rates—the third reduction in the past four years, and responding to the needs of its insured physicians. Since issuing its first policy in May, 1976, MPMLC has become the second largest writer of medical professional liability coverage in Michigan . . . and the 25th largest in the country.

MPMLC is prepared for the Age of Litigation.

Your
Company

**Michigan Physicians
Mutual Liability Company**

P.O. Box 1471
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926 toll free

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

The medical management of obesity

By David E. Schteingart, MD, Ann Arbor

The treatment of the obese patient is frequently a difficult undertaking. Patients fail to lose weight and drop out of weight reduction programs in large numbers; or, once they have lost weight, they rapidly regain it, and begin another equally frustrating cycle.

Doctor Schteingart is a Professor of Internal Medicine in the Division of Endocrinology and Metabolism at the University of Michigan Medical School. He is the Director of the Obesity Rehabilitation Program, a multidisciplinary treatment program supported in part by the Michigan Bureau of Rehabilitation.

As a result of these experiences, obese patients are frequently a captive audience for those who promote "rapid and effective" cures for their weight problems. And as the frustrated consumer frequently turns in desperation to medically unproven methods of weight reduction, the medical profession and public health administrators often are faced with the dilemma of how best to protect the consumer from unwarranted and dangerous claims.

Many methods of weight reduction which are offered to the public are ineffective and costly. Others may induce weight loss but are dangerous. The public needs to be educated on how to recognize the relative value and risks of such programs.

Optimal weight reduction programs aim at causing weight loss with the highest possible fat to lean body mass ratio and altering behavior in order to insure long-term weight loss and maintenance of normal weight. The basic components of these programs usually involve: a) Diet restriction, b) Physical exercise and c) Psycho-social and eating behavior modification. It is clear that long-lasting weight reduction ultimately depends on the ability of patients to develop long-lasting control of their eating behavior.

Diet restriction

For most adults, restriction of energy intake to as little as 1,000 to 1,200 kilocalories per day generally results in weight loss. However, the speed at which weight loss occurs varies from patient to patient. Also variable is the patient's willingness and ability to remain on a diet long enough to achieve the desired weight goal. Drastic dietary restriction ranging from total fasting to nutrient-modified fast has become a popular means of achieving rapid weight loss in cases where weight reduction is medically urgent or where more liberal approaches have failed.

Short term fasting as a means to bring about rapid and effective weight reduction became popular during the 1960's. Bloom, and later Duncan, advocated a seven to 10 day fasting period prior to institution of a hypocaloric diet in order to induce initial rapid weight loss, improve patient's compliance with subsequent diet therapy and minimize hunger

Long term follow-up of this treatment approach indicated that less than 20 percent of the patients were successful in maintaining a much lower weight than prior to fasting. Total fasting, extending for weeks or months, has been used occasionally in patients with morbid obesity. Total fasting is associated with important metabolic and clinical side effects and, therefore, patients treated in this manner should be hospitalized and kept under close medical supervision.

Side effects observed during starvation include ketoacidosis; at times severe hypoglycemia and loss of electrolytes, especially potassium, sodium, calcium, magnesium and phosphate. Severe negative nitrogen balance may cause the loss of body cell mass. The most worrisome complications of total starvation are those which involve the cardiovascular system, with volume depletion and associated postural hypotension and with arrhythmias, produced by myocardial fiber changes which can cause sudden death.

Because of the metabolic and clinical risks of prolonged fasting, attempts have been made to correct the undesirable aspects of starvation while retaining the potential for rapid and effective weight reduction. The addition of synthetic supplemental formulae containing dextrose and essential amino acids have allowed patients to lose large amounts of weight in a relatively safe manner. Thus, patients placed on these programs are able to lose weight for many months on an ambulatory basis. The protein used for supplementation of prolonged fast has been obtained from various sources, including egg albumin, meat, collagen hydrolystates, casein, etc.

A proliferation of commercial products for use as protein supplements developed in the mid-1970's. These "liquid protein" preparations contained amino acid mixtures, many of which were low in essential amino acids. These products were used indiscriminately by patients, often without medical supervision. Side effects from the use of these preparations included nausea, vomiting, diarrhea or constipation, blindness, muscle cramps, weakness, irritability, cold intolerance, amenorrhea, decreased libido, hair loss and dry skin. Most of these symptoms were probably secondary to starvation and not to the protein preparation per se.

By the end of 1977, the FDA had received reports of more than 40 deaths associated with the "liquid protein" diet. The CDC found that in at least 15 of these deaths, the diet was highly suspect as a contributing factor. While none had a history of heart disease, patients on these diets died suddenly of heart irregularity either while on the diet or shortly after they stopped it.

As a result of these observations, a panel convened by the FDA concluded in October, 1977, that these products should not be taken without supervision by trained medical personnel. A warning label is now required on these products.

More traditional severely hypocaloric diets, when properly implemented and closely monitored, have been shown to effectively and safely induce large and continued weight loss. Most effective are those which limit the caloric intake to 400-600 kilocalories daily and are restricted in carbohydrates, enhancing lypolysis and inducing ketosis. With persistent starvation, the brain and myocardium can effectively utilize free fatty acids and ketones as sources of fuel. Ketogenic diets have a protein sparing effect which also depends on the amount and quality of protein contained in them, the antecedent nutritional status of the patient, the number and source of nonprotein calories, the quantity of potassium and other elements and the length of time required for adaptation. There is growing evidence that after an initial phase of nitrogen deficit lasting one to two weeks, nitrogen equilibrium can be maintained for some weeks in obese persons who consume a diet restricted to 1-1.5 gm of protein per kg of desirable body weight. There is no available data, however, concerning the course of nitrogen balance when such diets are fed over many months. Ketogenic diets also have the advantage of possibly reducing hunger and providing, through the urinary ketones, an indicator that the patient is adhering to the prescribed diet program. For example, if a patient on this type of diet stops losing weight but

U.S. ARMY MEDICAL CAREER OPPORTUNITIES

We are looking for physicians who want to be physicians. We offer a practice that's practically perfect, where you work · without worrying whether the patient can pay, without endless insurance forms, malpractice premiums, and cash flow worries, and where you prescribe, not the least care, not the defensive, but the best. If that is what you want, join the physicians who have joined the Army. Write us or call collect for the following information. We can offer:

Specialty Assignments
Residencies
Fellowships
Internships
Health Professions Scholarships
Employment Opportunities

Captain Gerard Indrisano
AMEDD Procurement Office
Federal Bldg.
200 E. Liberty St.
Ann Arbor, Mi 48107
(313) 668-2190

ketonuria continues, a shift in fluid balance and fluid retention may be a likely explanation for the lack of weight loss. In contrast, a decline in the rate of weight loss with disappearance of ketones most likely signals deviations from total adherence to the prescribed diet program. Patients who are fed diets containing 400-600 calories daily can safely lose weight at a rate of 2.5 kg per week. These diets need to be supplemented with multivitamins and calcium.

Physical exercise

Physical training is an important component of weight reduction programs. While exercising, patients should be closely monitored for their response to the exercise prescription. Physical exercise not only increases caloric expenditure, but also has beneficial metabolic effects. It improves sensitivity of peripheral tissues to insulin and may help improve glucose tolerance in obese patients with mild diabetes. It also seems to decrease the degree of negative nitrogen balance associated with very restricted diets. Exercise enhances the loss of adipose tissue and the preservation of lean body mass. A possible beneficial effect of physical training on blood lipids has been described. Before participating in an exercise program for weight reduction, patients need to have a graded exercise test to determine their maximum work capacity and associated heart rate under laboratory controlled conditions, as well as the presence of underlying cardiovascular disease which may limit their ability to exercise. The most desirable type of exercise for obese patients is aerobic, progressive intensity, endurance type exercise (walking, jogging, swimming). Patients should work out at 70 percent of their maximal heart rate for at least 30 minutes four times a week for optimal training effect.

Adherence to weight reduction programs and long term success largely depend on the ability of patients to alter eating behavior. Since eating behavior is influenced by the individual's reaction to environmental stress, changes in this behavior will need either a resolution of underlying conflicts or the learning of new ways of dealing with these conflicts. Since environmental eating cues frequently contribute to overeating, learning to manipulate the environment in order to minimize stimuli to overeating is a prerequisite for change in eating behavior. Without these changes, patients are likely to return to old patterns and to regain their weight.

Psychosocial and eating behavior modification

Weight reduction for the patient who needs to lose 20 to 30 lbs requires only diet counselling and eating behavior modification. These interventions can be easily implemented by physicians, dietitians and other health professionals. In contrast, patients who need to lose large amounts of weight and who have medical complications for which weight reduction is essential often require combinations of properly selected therapies administered by a trained multidisciplinary treatment team, frequently in the controlled environment of a hospital setting. Most importantly, behavioral and psychosocial intervention by qualified professionals specially trained to deal with eating disorders are a prerequisite for the attainment of long-lasting results.

Many other techniques and devices are frequently offered to the public as effective means for achieving general or local weight reduction. These consist of bizarre diets, pills, fillers, appliances, body wraps and hormones. Although the promoters of such devices promise instant results, they usually do not withstand hard scientific scrutiny as to their effectiveness and many of them may be outright dangerous.

Protection of the consumer from misleading advertising about weight reduction programs will require a concerted and organized effort on the part of the medical profession and the media with the guidance and support of public health agencies. This effort should be directed to making the public aware of what is fact or fancy in the area of weight control.

It is clear that the obese patient seeks unorthodox methods of weight reduction as a result of the relative ineffectiveness of physicians in general to deal with their problem. In fact, patients who would require hospitalization for weight loss find that treatment of obesity is usually excluded from health care coverage contracts.

More effective methods for weight reduction may become available once the bio-medical and behavioral factors involved in the pathogenesis of obesity are better understood. In the meantime, it is important that the health profession and third party payers recognize that obesity is a legitimate medical concern for which the public is entitled to receive adequate care.

On job/on campus MPH program in Medical Care Administration recruits new class

The Department of Medical Care Organization and the program in Dental Public Health in the School of Public Health, University of Michigan are now accepting application for enrollment into the seventh On Job/On Campus (OJ/OC) class which will begin in January 1982. The OJ/OC Master of Public Health program is offered to employed professionals in the health delivery system. Former participants have been employed in ambulatory services management, HMO development and operations, health planning, dental public health administration, hospital administration, third party services and health manpower training.

The program provides 47-49 credit hours of coursework covering: managerial tools and approaches useful in health care including financial management, operations research and organizational behavior; background disciplines to health care administration including health economics, health behavior and politics of health care; statistics, epidemiology and demography; and medical care organization, administration and financing, ambulatory care, health insurance and medical care law.

For additional information contact David Perlman, Student Services Coordinator, On Job/On Campus Program, Department of Medical Care Organization, School of Public Health, University of Michigan, Ann Arbor, 49109.

HE LEFT TOWN OWING YOU MONEY.

NOW WHAT?

When someone comes to you for treatment and fails to pay, it's tough to collect. But when he moves out of state, it's next to impossible. Why run up your phone bill? Call on I.C. System — a nationwide collection service, approved by the Michigan State Medical Society. Whether your former patient has moved across town or across the nation, let I.C. cover the extra miles for you. Mail this coupon today and learn how far...

The System Works ®

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ____________________
Address ____________________
City ____________________
State ____________________ Zip __________
Signature ____________________

Same-day appointment makes better service, happier patients

By Elmer E. White, special to Michigan Medicine

REGISTRATION & EDUCATION
PHYSICIAN and SURGEON

"The long wait" was the most important objection people had when they were questioned in a research project by a leading retail operation.

The progressive merchant responded by reorganizing the check-out service so that customers had minimum time at the check-out counter. Not only did business improve, but customers were appreciative and grateful.

Similarly, over and over, "the long wait" in some doctors' offices has been identified as a major complaint of those who need medical care. Although doctors know that frequently the wait by the patient is justifiable, the patient does not appreciate the doctor's problems.

Doctors do understand that patients are often under time constraints, too. He/she knows children must be picked up, other plans must be dealt with, even that meals must be prepared.

Efforts by physicians or their personnel which indicate consideration of the patient's time are usually appreciated by the patient. It is also helpful to the professional relationship when the patient understands that the doctor does care and is trying to reduce waiting time.

Okemos solution

Donald Aiken, MD, and Gary Gillespie, MD, of Okemos are two who have made gains in this area of patient relationship.

Doctor Aiken, who has been in practice in the same office for 23 years, has always been sensitive to the patient's emotional need for early attention. "I have realized they want to be seen today — not next week," he says.

Doctor Gillespie, his associate of five years, also recognizes the importance of seeing patients promptly so as to provide for the ill or anxious patient who calls that day.

Together they developed a plan which blocks out an appropriate number of appointments in anticipation of calls from people who need to be seen the same day. They did this by noting the number of people who called in each day over a period of time, then estimating how a similar number could be projected for the future.

The "open schedule" time varies from day to day as the need is greater on Mondays, Friday, holidays, or in the flu season. Open time is interspersed throughout the day and usually fills without problem.

This means that a patient who calls in symptoms which developed overnight (or may have been present for a week or so without concern) can be told to come in the same day and at a specific time.

It works

The plan is simple enough. How well does it work?

It works very well for patients who are pleased to be seen so rapidly. Some people indicate they appreciate the "special" consideration, although the fact is that this slightly sophisticated scheduling plan is open to all patients.

"It is true," says Doctor Aiken, that once in a while "we run short of patients." That happens when fewer than estimated phone for attention that day. This occurs seldom, he says, and can usually allow the closing of the office on time, or rarely, a little early.

The ideal number of patients for each doctor to see ranges between 35 to 50 each day. Each doctor's schedule includes no more than four physical examinations for which 30-40 minutes is allowed.

Because of their system which aims at getting patients to doctors the same day they call for such service, Drs. Aiken and Gillespie report few complaints from those needing attention; and that they sense a feeling of gratitude among patients for their service.

The plan is really a simple one which takes some careful consideration of patients and their need to see a doctor when they feel in distress.

The nicest thing about it is that it works.

ST. CLAIR AMBULATORY CARE CORPORATION

Detroit, Michigan

IS ACCEPTING APPLICATIONS FOR THE FOLLOWING POSITIONS IN A NEW AMBULATORY CARE CENTER IN THE NORTHEAST DETROIT SUBURB OF ST. CLAIR SHORES.

1. INTERNIST; GENERAL MEDICINE WITH OR WITHOUT SUBSPECIALTY
2. OBSTETRICIAN-GYNECOLOGIST
3. PEDIATRICIAN; GENERAL PEDIATRICS

THE NEW ST. CLAIR AMBULATORY CARE CENTER WILL BE A GROUP PRACTICE DEVOTED TO PRIMARY CARE, INITIALLY WITH TWO INTERNISTS, TWO OBSTETRICIANS, AND TWO PEDIATRICIANS WITH EXPANSION TO FOUR OF EACH AS INDICATED. COMPENSATION IS BASED PRIMARILY ON INCOME GENERATED WITH EXCELLENT FRINGE BENEFITS, AND A TWO YEAR INITIAL GUARANTEE.

APPLICANTS SHOULD BE BOARD CERTIFIED OR ELIGIBLE AND WILL NEED TO BE ACCEPTED FOR STAFF PRIVILEGES AT ST. JOHN HOSPITAL, AN AFFILIATE ALONG WITH ST. CLAIR AMBULATORY CARE CORPORATION, THE OXFORD INSTITUTE, AND THE ST. CLAIR RENAL CENTER, OF ST. CLAIR HEALTH SERVICES CORPORATION. APPLICANTS MAY APPLY IN CONFIDENCE TO:

ROBERT E. BIRK, M.D., F.A.C.P.
DIRECTOR, MEDICAL AFFAIRS
ST. CLAIR AMBULATORY CARE CORPORATION
22151 MOROSS ROAD
DETROIT, MICHIGAN 48236
(313) 343-3875

Administrative office and main laboratory

AMRC the full service laboratory

- Complete range of individual tests and diagnostic profiles
- Medical consultation services
- Comprehensive quality control program
- Fully accredited
- Complete billing service

Advance Medical &
Research Center, Inc.

1270 Doris Rd • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Ophthalmological Society
Michigan Psychoanalytic Society
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Office of Resource Development, Michigan Department of Health.
Section of Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Bay County Medical Education (Bay Medical Center, Bay Osteopathic Hospital, Bay City Samaritan Hospital)
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Northern Michigan Hospitals Inc., Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Dickinson County Memorial Hospital, Iron Mountain
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospitals, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital, Muskegon)
Leila Y. Post Montgomery Hospital, Battle Creek
Marquette General Hospital
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Metropolitan Regional Psychiatric Hospital
Michigan Psychoanalytic Society, Southfield
Midland Hospital Center
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital
Oakwood Hospital, Dearborn
Orthopedic Guild, Inc., St. Joseph
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Portage View Hospital, Hancock
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Southwest Detroit Hospital
Edward Sparrow Hospital, Lansing
Traverse City Regional Psychiatric Hospital, Traverse City
V.A. Hospital, Battle Creek
West Shore Consortium, CME, Ludington/Hart/Manistee
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

Date: June 26-28, Urology Outing. Locat
Grand Traverse Hilton, Traverse City. **Spon**
Wayne State University School of Medicine
vision of Continuing Medical Education.
All interested physicians. **Cost:** $150. **Con**
Wayne State University School of Medicine
vision of Continuing Medical Education, 9
DRHUHC, 4201 St. Antoine, Detroit, 48
313/577-1180. **Approved for:** 12 hours of C
gory I Credit.

Date: July 9-12, Eighth Annual Michigan E
gency Medicine Assembly. Location: G
Hotel, Mackinac Island. **Sponsor:** Michi
Chapter, American College of Emergency Ph
cians. **For:** All interested physicians. **Con**
Catherine C. Sleicher, Executive Direc
Michigan Chapter, ACEP, 1305 Abbott R
Suite 102, East Lansing, 48823. 517/332-6
Approved for: 26 hours of Category I Credit

Date: June 15-19, Basic Principles of Ma
Medicine. Location: Kellogg Center, MSU,
Lansing. **Sponsor:** Michigan State Univer
College of Osteopathic Medicine. **For:** All
terested physicians. **Contact:** Sandy Kilbo
Coordinator CME, 517/353-8822. **Approved**
40 hours of Category I Credit.

Date: June 19-21, Keyport-Gaylord Tra
Symposium. Location: Hidden Valley C
Gaylord. **Sponsor:** Wayne State Univer
School of Medicine. **For:** All interested ph
cians. **Contact:** Benjamin Henig, MD, Key
Clinic, 308 Michigan Ave., Grayling, 49
Approved for: 12 hours of Category I Credit

Date: June 19-21, Michigan Dermatological
ciety Annual Meeting. Location: Renaiss
Center, Detroit. **Sponsor:** Michigan Dermato
ical Society. **For:** All interested dermatolog
Contact: Alejandro Morales, MD, 1015 F
wood, Royal Oak, 48067. **Approved for:** 6 h
of Category I Credit.

Date: July 26-29, 13th Annual Summer Co
ence. Location: Grand Hotel, Mackinac Isl
Sponsor: Michigan Opthalmological Soci
For: All interested opthalmologists. **Cont**
Philip C. Hessburg, MD, 15401 E. Jeffer
Grosse Pte. Park, 48230. **Approved for:** 8 h
of Category I Credit.

Date: July 30-31, Coller Penberthy Thirlby M
ical Conference. Location: Park Place M
Inn, Traverse City. **Sponsor:** Munson Med
Center. **For:** All interested physicians. **Cont**
Norma Powers, Coordinator of Medical Ed
tion, Munson Medical Center, 6th & Mad
Streets, Traverse City, 49684, 616/947-6140,
146. **Approved for:** 9 hours of Category I Cre

Date: July 31-Aug. 2, EKG Interpretation
Arrhythmia Management. Location: Sh
Creek Hilton Resort, Bellaire. **Sponsor:** Inte
tional Medical Education Corporation. **For:**
interested physicians. **Cost:** $310. **Cont**
IMEC, 64 Inverness Drive East, Englewood,
orado 80112. 1-800-525-8646. **Approved for**
hours of Category I Credit.

Date: Aug. 18-21, Michigan Health Offi
Association Annual Meeting. Location: Hol
Inn, Traverse City. **Sponsor:** Michigan He
Officers Association. **For:** All interested ph
cians and health officers. **Contact:** William
Moon, MD, Box 43, Harrietta, 49638. **Appro**
for: 5 hours of Category I Credit.

Date: August 29-30, Anatomy and Technic
of Regional Anesthesia. Location: Gordon
Scott Hall, Wayne State University, Det
Sponsor: Wayne State University Schoo
Medicine, Division of Continuing Medical E
cation. **For:** All interested physicians. C
$175. **Contact:** Wayne State University Sc
of Medicine, Division of Continuing Med
Education, 9B-32 DRHUHC, 4201 St. Anto
Detroit, 48201. 313/577-1180. **Approved for**
hours of Category I Credit.

e: Sept. 14-18, Eighth Annual Family Prac-
Review. Location: Gordon H. Scott Hall,
yne State University, Detroit. **Sponsor:**
yne State University School of Medicine, Di-
on of Continuing Medical Education. **For:**
interested family physicians. **Contact:**
yne State University School of Medicine, Di-
on of Continuing Medical Education, 9B-32
HUHC, 4201 St. Antoine, Detroit, 48201.
/577-1180. **Approved for:** 40 hours of Cate-
y I Credit.

e: Sept. 16, Renal Disease for the Clinician.
:ation: Kalamazoo Hilton Inn. **Sponsor:**
:higan Nephrology Center. **Co-Sponsor:**
ithwestern Michigan Area Health Education
iter. **For:** All primary care physicians. **Con-**
:: Charles L. Zeller, Jr., MD, Director/CME,
AHEC, 252 E. Lovell, Room 364, Kalamazoo,
07. **Approved for:** 7 hours of Category I
dit.

e: Sept. 25-27, Diagnostic Ultrasound. Loca-
ı: Towsley Center, Ann Arbor. **Sponsor:** Uni-
sity of Michigan Department of Radiology
Department of Postgraduate Medicine and
ılth Professions Education, and the Univer-
of Michigan Medical Center. **For:** All in-
ısted physicians. **Contact:** Robert P. Means,
D., Towsley Center for CME, University
dical Center, Ann Arbor, 48109, or phone
/763-1423. **Approved for:** 16 hours of Cate-
y I Credit.

e: Aug. 28-31, Advances in the Management
Infectious Diseases. Location: Grand Hotel,
ckinac Island. **Sponsor:** Department of Post-
duate Medicine and Health Professions Edu-
ıon, University of Michigan Medical Center.
; All interested physicians. **Contact:** Janet
nson, Office of CME, Towsley Center, U-M
dical Center, Ann Arbor, 48109, or call 313/
-2287. **Approved for:** 11 hours of Category I
dit.

Date: Oct. 8-11, Regional Meeting, Michigan Chapter, American College of Physicians — Michigan Society of Internal Medicine. Location: Boyne Highlands, Harbor Springs. **Sponsor:** American College of Physicians and Michigan Society of Internal Medicine. **For:** All internists and primary care physicians. **Cost:** $30. **Contact:** Boy Frame, MD, FACP, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. **Approved for:** 21 hours of Category I Credit.

Date: Oct. 11-15, 1982, Abortion: Spontaneous and Induced. Location: Maui Surf Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1011. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-15, 1982, CDS: Contraceptive Delivery Systems. Location: Maui Marriott Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1101. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-16, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

Date: Oct. 15-17, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **For:** All interested physicians. **Cost:** $300. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, S.E., Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

"So what's the problem? Didn't Humpty Dumpty carry Major Medical?"

"Quality" United States & Canadian Decimals Since 1958

CARLTON
NUMISMATICS, INC.

- Professional Numismatic Counseling
- Acquisition of Rare Coins
- Portfolio Management
- Investment Programs

via
I.R.A., Keogh & Pension and Profit Sharing
Retirement Plans

To receive your complimentary copy
of our Current Price List and
Descriptive Brochures,
please write or telephone:

Bingham Center • Suite 1646
30700 Telegraph Road
Birmingham, Michigan 48010
313 / 646-8846

BUSINESS HOURS:
Wednesday - Saturday 10:00 A.M. to 3:00 P.M. and by appointment.

Life Members A.N.A, C.N.A., M.S.N.S.: Associate Members C.A.N.D.

LOCUM TENENS

EMERGENCY MEDICAL POSITIONS

Emergency Consultants, Inc. has select opportunities in emergency medicine available on a locum tenens or full time basis. Positions in resort and recreational areas offer flexible scheduling, competitive hourly rates, and excellent benefits including malpractice insurance.

Emergency Consultants, Inc., a physician owned and operated corporation, currently services 60 hospitals in 12 states. Our organization accommodates professional and personal physician goals by providing a wide variety of locations with varying patient volume.

For further information contact: Emergency Consultants, Inc., Suite 115, 2240 South Airport Road, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

MEETINGS

MSMS, MSMS/A, AMA and medical assistants

July 16-19 — MSMS Council, Grand Traverse Hilton, contact: Warren Tryloff, MSMS headquarters.

July 18 — 1981 AMA Seminar for Improving English Pronunciation for Foreign Medical Graduates, AMA headquarters, contact: Department of Resident Services, AMA, 535 N. Dearborn, Chicago, 60610.

July 18-19 — Summer Seminar, State of Michigan Branch, American Association of Medical Assistants, Petoskey Holiday Inn, contact: Caroline Rich, MSMS headquarters.

Sept. 9 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Sept. 10-11 — AMA 41st Annual Congress on Occupational Health, Milwaukee, contact: Barbara S. Jansson, AMA, 535 N. Dearborn, Chicago, 60610, 312/751-6669.

Sept. 18-19 — AMA Hospital Medical Staff Leadership Seminar, The Drake Hotel, Chicago, contact: Department of Hospitals and Health Facilities, AMA, 535 N. Dearborn, Chicago, 60610, 312/751-6656.

Sept. 18-28 — MSMS/Intrav Italian Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

Oct. 21 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Nov. 3-4 — Diet & Exercise: Synergism in Health Maintenance, sponsored by the AMA, Walt Disney World Complex, Florida, contact: AMA Department of Foods and Nutrition, 535 N. Dearborn, Chicago, 60610.

Nov. 7-8 — Fall Seminar, State of Michigan Branch, American Association of Medical Assistants, Holiday Inn, Battle Creek, contact: Caroline Rich, MSMS headquarters.

Nov. 17-19 — 1981 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS
headquarters, contact: Warren T
loff, MSMS headquarters.

Other meetings

June 24-26 — Michigan Hospital
sociation Annual Meeting, Macki
Island, contact: Michigan Hospi
Association, 2213 Grand River Av
Lansing, 48912.

July 11 — Medical Malpractice, F
eral Taxation, Professional Corpo
tions, Workers' Compensation a
Investments, sponsored by prof
sional Medical Seminars Ltd., Alb
Pick Motel, East Lansing, conta
Richard D. Carr, 421 Seymour
Lansing, 48933, 517/485-6010.

July 29-30 — 24th Annual Congr
of Delegates Meeting, Michig
Academy of Family Physicia
Holiday Inn, Traverse City, conta
Loretta Joyce, Executive Direct
MAFP, 416 N. Homer, Suite 1
Lansing, 48912.

Aug. 3-5 — 35th Annual Michig
Academy of Family Physicians S
entific Assembly, Traverse City, c
tact: Loretta Joyce, Executive Dir
tor, MAFP, 416 N. Homer, Suite 1
Lansing, 48912.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
143 Courtland Avenue
Rockford, Michigan 49341
(616) 866-9395

EATHS

arles E. Black, MD
illiamston

arles E. Black, MD, Williamston,
d April 7 at the age of 75. Doctor
ck received his MD from the Uni-
sity of Chicago Rush Medical Col-
e in 1936. He was a pathologist for
arrow Hospital and served for a
mber of years as state pathologist,
resenting the Michigan State
lice. He was a member of the
erican Board of Pathology, the
erican Society of Clinical Pathol-
sts and the American Society of
ology.

Frank J. Busch, MD
Saginaw

Frank J. Busch, MD, Saginaw, died March 21. He was 70. Doctor Busch earned his MD from the Northwestern University Medical School in 1935. He maintained a practice in Saginaw from 1938 until his retirement in 1980. He was past president of the Saginaw County Medical Society and former chief of staff at Saginaw General Hospital.

Meyer O. Cantor, MD
Bloomfield Hills

Meyer O. Cantor, MD, Bloomfield Hills, died March 23 at the age of 74. He was president of the US Section of the International College of Surgeons and a fellow of the American College of Surgeons. He also served as past president of the American Society of Abdominal Surgeons and editor of the Journal of Abdominal Surgery from 1966 to 1978. He received his MD from the University of Michigan Medical School in 1930.

Paul B. Wollschlaeger, MD
Birmingham

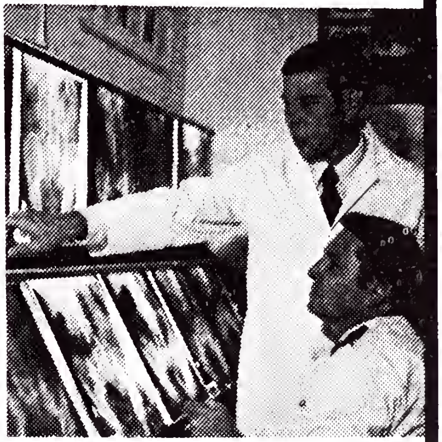
Paul B. Wollschlaeger, MD, Birmingham, died March 27. He was 61. Doctor Wollschlaeger was on the staff of the Wayne State University School of Medicine. He was a member of the American Society of Neuro-radiology, the Association of University Radiologists and the American Heart Association. He earned his MD from the Ludwig Maximilian Medical School in Munich, Germany, in 1955.

AN ATTRACTIVE ALTERNATIVE TO PRIVATE PRACTICE —
AIR FORCE MEDICINE

Did you go to medical school to become a doctor or an office manager, supply clerk, or repairman? If you want to concentrate on your medical practice and leave the administration to someone else, then Air Force medicine can be an attractive alternative to your private practice. You see, the Air Force uses a group practice system of health care. This system allows maximum contact between patient and physician with a minimum of administrative responsibilities. Nurses and technicians take care of the paperwork while you take care of the patients. You'll get to use the skills gained through years of education; to stay abreast of new methods and techniques; and, for qualified physicians, to specialize. These benefits, along with our excellent employment package, make Air Force medicine an attractive alternative to private practice. Find out how you can be a part of the Air Force health care team. We'll answer all your questions promptly and without obligation.

Contact at 23400 Michigan Ave., Village Plaza, Dearborn, MI (313) 561-7018.
In Ann Arbor: (313) 668-2047. In Lansing: (517) 372-3133.

AIR FORCE
A great way of life.



CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

PLANT PHYSICIAN. Large industrial organization in Saginaw, Michigan, area has opening for medical doctor. Candidates should write to Box 18, Michigan State Medical Society, 120 W. Saginaw St., East Lansing, MI 48823.

DIRECTOR-FAMILY PRACTICE CENTER, FAMILY PRACTICE RESIDENCY PROGRAM: Holy Cross Hospital is looking for a physician to develop and direct a combined family practice service and education program in cooperation with the Department of Family Medicine, Wayne State University's School of Medicine. Candidates must be certified by the American Board of Family Practice with teaching and administrative experience in a family practice residency program. Salary will be competitive with private practice. A full spectrum of benefits will accompany this position, including a faculty appointment within the Department of Family Medicine, Wayne State University's School of Medicine. Please forward resume to: Bernardo M. Danan, MD, Chief of Medical Staff, Holy Cross Hospital, 4777 E. Outer Drive, Detroit, Michigan, 48234. An equal opportunity employer M/F.

POSITION NOW AVAILABLE in the Department of Internal Medicine for physician with subspecialty interest. 50 man multispecialty clinic in ideal location in Southern Wisconsin. Contact: R. E. Hassler, MD, The Monroe Clinic, Monroe, WI 53566, (608) 328-7000.

OPHTHALMOLOGIST WANTED to do office ophthalmology two or three days a week in well-equipped suburban office outside of Detroit. Excellent terms. Reply to Box 19, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

OPHTHALMOLOGIST FULL-TIME, outstanding opportunity to join busy practice in suburb of Detroit. Reply to Box 20, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

GENERAL PRACTICE FOR SALE: Unopposed, in small community in Michigan Upper Peninsula. Three miles from 72 bed hospital. One story Marshal Erdman building, fully equipped, with reception room, three examination rooms, business and priviate office, lab, x-ray and full basement. Five miles from three major ski areas. Plus miles of cross country ski trails and a network of snowmobile trails. Hunting, fishing and varied summer and winter recreation. Retiring. Phone collect (906) 667-0881. Donald L. Davidson, MD, Bessemer, Michigan, 49911.

POSITION AVAILABLE. Family practice, educational program director. Applications are being accepted for this full time staff position with the Southwestern Michigan Area Health Education Center. This is a challenging opportunity in a clinically stimulating environment with an academic atmosphere. To be considered, an individual must be a fully trained family physician and certified (or imminently so) by the American Board of Family Practice. Duties and responsibilities will encompass many areas of activity, including undergraduate, graduate, and continuing medical education. A complete job description is available upon request. Compensation will include an appropriate stipend and fringe benefits package as well as a regular appointment to the faculty of the College of Human Medicine of Michigan State University. For details, contact: Robert M. Nicholson, MD, Executive Director, Southwestern Michigan Area Health Education Center, 252 E. Lovell Street, Kalamazoo, MI 49007, 616/383-7896.

NEED FULL TIME OR PART TIME PHYSICIAN OR P.A. in a busy general practice in semi-rural set-up close to Ann Arbor. Some industrial and insurance physicals. Very interesting and varied. Salary negotiable and commensurate with experience. Please call 313-697-9300 or send resume to Belleville Medical Clinic, 265 Main Street, Belleville, MI 48111.

PHYSICIAN NEEDED for Jackson Medical Center, Inc., a non-profit clinic providing medical care for patients in need, regardless of ability to pay. A permanent position with very attractive salary (approximately $50,000.00), 30-40 hour work week, no weekends, no nights, no hospital duty. Prefer family physician. Contact: E. Willoughby, MD, 569 Wildwood Ave., Jackson, MI 49201.

PHYSICIANS NEEDED IN ROGERS CITY AND POSEN, MICHIGAN. Excellent opportunity for physicians seeking a wide variety of financially rewarding professional experiences. Located near Lake Huron with excellent outdoor and family lifestyle. Attractive income guarantee in solo or group practice settings. If interested, call collect to: Evans Calas, Assistant Administrator, Rogers City Hospital, (517) 734-2151.

PRIMARY CARE PHYSICIAN NEEDED to join staff at growing practice in scenic central Virginia, near Lynchburg. Enjoy well-equipped facility, excellent staff, strong community support, guaranteed income, excellent linkages with hospitals and other providers in area with beautiful mountains, large lakes, and year-round mild weather. Strong local economy. Unemployment rate only 4.6% and population is growing! Contact: John Troidl, Administrator, Evington Medical Center, Evington, Virginia 24550. (804) 821-3136.

MEDICAL ONCOLOGY FELLOWSHIP. Currently available for 1 or 2 years at the Edward W. Sparrow Hospital, Lansing, Michigan. Emphasis on clinical training with research opportunities, including work in interferon trials. Prefer applicant who has completed 2 years of internal medical training. Send curriculum vitae to: Francis A. Breen, Jr., MD, Director of Medical Oncology, Edward W. Sparrow Ho
tal, 1215 E. Michigan Ave., Lansing, Michi
48909. A Non-Discriminatory Affirmative Act
Employer.

FAMILY PHYSICIAN TO JOIN two Board
tified family physicians and one physician's
sistant in a young and growing medical p
tice in central Minnesota. The practic
oriented toward family medicine. The prac
is located centrally in the state with quick
cess to Minneapolis/St. Paul. Cultural and
reational activities are in abundance in
area of Minnesota. Salary open: Contact D
G. Mathews, Adm., or Thomas J. Newton,
at the Cold Spring Medical Clinic, 26 N.
River Ave., Cold Spring, MN 56320. Call
685-8641.

CALIFORNIA-DIRECTOR POSITIONS AV
ABLE. Emergency medicine physicians nee
for rural Northern California areas. Excel
opportunity to join growing partnershi
career emergency physicians. Emergency m
ical residency, Board Certification or at l
two years experience required. Excellent b
fit package and profit-sharing. Contact J
Neal, California Emergency Physicians,
Grand Ave., Suite 500, Oakland, CA 94
415/832-6400.

GENERAL PRACTICE FOR SALE — F
Michigan, due to retirement. Office for on
two doctors available immediately. Grossin
6 figures. No ob. No medicaid. Replies to
15, MSMS, 120 W. Saginaw, East Lansing
48823.

OB-GYN: Board eligible or certified to
busy practice in a beautiful resort area clos
Detroit. Excellent office located one mile f
hospital. No investment required. Equal w
Salary open. Partnership available after firs
year. M. I. Sabbagh, MD, P.O. Box 163,
Clair, 48079. 313/329-7000.

PART-TIME PHYSICIAN needed to do rou
physicals to assess donor suitability
plasmapheresis. Good position for o
physician looking to slow down. Malprac
coverage provided. Contact Thomas Ande
at American Plasma Management, Kalama
MI. Phone 616/381-0086.

Positions with The State Of Michigan —
rently taking applications for positions
pected to be available in the future. Prim
interested in board certified or board elig
internists with cardiology background. Of
locations in Southfield, Lansing, and Trav
City. Also considering an office in Kalama
Salary in 50's with approximately 40% fri
benefits. An equal opportunity employer.
inquiries treated confidentially. For further
tails please write: Disability Determina
Service, P.O. Box 30011, Lansing, MI 4890
call collect: Harry D. Nesmith, MD, Chief M
cal Consultant (517) 373-7830. In Michigan,
toll free 1-800-292-2710.

OB/GYN PARTNERSHIP — Young ob/gy
cated in Southern Illinois, with an expan
practice, needs a partner. This pleasant c
munity is family oriented, with good sch
and a new hospital. All replies will be kept

ntial, send to Box 14, MSMS, 120 W.
inaw St., East Lansing, MI 48823.

SOURI OB/GYN, group opportunity with
family practitioners. Offices adjacent to
ital. Excellent family area, with relaxed life
in small town, near several large cities.
ctive financial arrangements. Send replies
onfidence to Box 13, MSMS, 120 W. Sagi-
St., East Lansing, MI 48823.

TUCKY TOWN NEEDS GP — friendly town
astern Kentucky, has hospital in adjacent
with complete services and specialists.
hospital and community will provide a
plete financial package to insure a suc-
ful practice. All replies kept confidential.
tact Administrator, Box 12, MSMS, 120 W.
naw St., East Lansing, MI 48823.

TNER NEEDED — by Arkansas GPs — two
blished physicians with office near hospi-
eed third physician GP or internist for
practice located in the beautiful Bull
als area. Attractive financial arrangements.
replies in confidence to Box 11, MSMS,
W. Saginaw St., East Lansing, MI 48823.

scellaneous

PETERSBURG, FLORIDA. Magnificent
er ground level 2 bedroom-2 bath condo
on the beach. Sliding glass walls given
astic view of bay with no building to
ruct view and open onto luxurious seaside
and sand beach. Only a few steps to
ed pool, jacuzzi and game room. Located
rivate resort recreational complex with
tennis, sailing, fishing and private bar and
t restaurant. Busch Gardens, Disney World,
ai, dog and horse racing all nearby. We
it and you will too. Great weather May,
, July with constant pleasant breeze and
fic off season rates — only $200/week and
/month. Also scheduling entire next sea-
(most of March and April 1982 already
). So call or write for information soon.
) 786-1308, Ray Hockstad, MD, 1614 S.
St., Escanaba, MI 49829.

ON HEAD ISLAND, SC. Ocean Villa, Cap-
s Cove in Palmetto Dunes Resort. Luxuri-
new villa, 150 yds from beach. Lagoon
yard, 2 bedrooms, 2 baths, sleeps 6. Ex-
nt golf, tennis, pool, fishing, canoeing,
g, etc. Weekly, monthly. Call or write,
) 695-0356, 6236 Kings Crown Rd., Grand
c, MI 48439.

MICHIGAN WINTERIZED LAKE HOME.
ded acre. 100 ft. Lake Huron frontage. 2
ooms and sleep loft. Full drive, garage,
ment, appliances. $70,000. (313) 549-7621.
ison, 3019 W. 13 Mile, Apt. 219, Royal Oak,
3.

SALE — MEDICAL BUILDING on busy
Arrow Highway in southwestern Michigan.
sard Roof Building has parking for twenty
. Ideally suited for professional services
h as doctor or dentist with twelve office
ms carpeted, air conditioned and stereo
ipped. Includes magnificent lower level one
room apartment. Sale price $139,900. Call
k Fuller at Bun Baldwin Co., (616) 465-6863.

BEAUTIFUL CHALET ON LAKE SUPERIOR 20 miles from Marquette on 10 acres of woods with 330′ lakeshore frontage. Cathedral living room with Franklin wood stove. Sleeps 8-10 comfortably with two bedrooms and large sleeping loft. Gas heat, lights, refrigerator and hot water. Fully insulated and furnished. No phone! Easy access 7-8 months of year. Only one other home in area. Doctor or Mrs. Robert White. (906) 225-1933. $53,500.

FOR SALE OR EXCHANGE — BY OWNER. Beautiful, almost-new summer home on approximately 12 acres on private lake with 400′ frontage. No motor boats allowed. Nearly 2 miles back in the woods, between Bitely and Baldwin, Michigan, adjacent to the 60,000-acre Manistee National Forest. 4 bedrooms, 3 baths, large rec room, large living room-dining room-kitchen combination. Laundry room with washer and dryer. Compactor, central vacuum system, public address and radio throughout. Air conditioning, gas furnace, deep well. 2 large fireplaces with heat-a-lators. Anderson Thermo-Pane windows. Wood paneling, carpeted, furnishings, including boats. All that and purple martins, too! Seller will finance at 12%. Price $149,500. Phone (616) 361-8439.

LUXURY CHALET FOR SALE, beautifully furnished, 5 large bedrooms, 3 full baths, in all-season northern Michigan resort. Golf, tennis, skiing, water sports, hunting, fishing, near excellent airport. Ideal for two-family or corporate ownership, too. Owner, (616) 587-9241 after May 25.

DOCTORS-PHARMACISTS-OFFICE & RETAIL SPACE AVAILABLE. Will build to suit. Corner of Gratiot & 27 Mile Rd. Just minutes from St. Joseph & Mt. Clemens General Hospital. Call Ron . . . 749-9595.

LAMINAGRAPHY SYSTEM — Approximately 15 years old. G.E. 300 ma, 125 KVP, Phillips table. Excellent condition, $9,800. Doctor S. G. Hastings, Box 335, Dexter, MI 48130. (313) 426-4632.

SANDRA W. COCHRAN, MEDICAL ILLUSTRATOR. Medical illustration available, from detailed realistic renderings to simple diagrams, graphic design and biophotography. For quality illustrations at the lowest cost, call (313) 652-2547, or write 1163 Ironwood Court, Apt. 104, Rochester, Michigan 48063.

WE HAVE VARIOUS QUANTITIES OF MEDICAL EQUIPMENT available in excellent condition. We buy, sell, trade, move. New equipment also available. Call Doctor Medical Resale, (313) 569-4407, 9 a.m. to 9 p.m.

St. Clair Michigan — Modern medical office, near hospital, 1200 sq. ft., available January 1981. Good growth location and pleasant living. Ample parking. Reasonable rent. Call M. I. Sabbagh, MD, 1-313-329-7000.

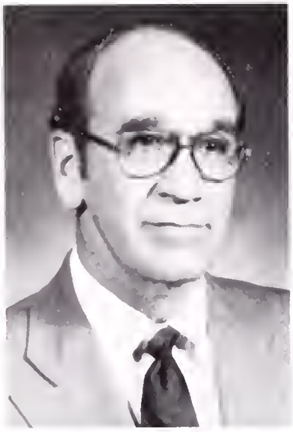
HOWELL, MICHIGAN — Two suites available in attractivley designed medical-dental building. Complex conveniently located within walking distance of hospital which serves fastest growing county in the State. Unlimited opportunity for hard-working family practitioner looking to establish large practice. For information, call (517) 546-7630.

OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury two & three bedroom units. Near Boyne ski hills. $92,000-$96,500. Furnished unit rentals available for vacation year round. A.K. Smith & Son Realty, Box 478, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

Thanks to our advertisers

Advance Medical and Research Center	327
American Red Cross	286
Brown Pharmaceutical	283
Burroughs Wellcome	303
Carlton Numismatics	329
CBC Labs	309
Eli Lilly	301
Emergency Consultants	329
Emergency Medicine Foundation	300
I.C. System	325
Marion Labs	291
Medical Protective	330
Merrell Dow	288, 289
Michigan Bell Telephone Co.	313
Michigan Physicians Mutual Liability Company	321
MSMS Physician Service Group	300
Pennwalt	315, 316, 317, 318
Physicians Insurance Company of Michigan	307
Purepac	295
Roche	276, 277, 278, 286, 287, IBC, BC
Sequoia Group	285
St. Clair Ambulatory Care Corporation	327
Stratton Cheeseman	293
U.S. Air Force	331
U.S. Army	323
Wyeth Labs	297, 298



PRESIDENT'S PAGE

Portents of the future from inaugural address

James D. Fryfogle, MD, MSMS President

I would like to broad brush for you three of the Society's current problems and opportunities that need thought and action:

1. GMENAC
2. The slow death of Federal Health Planning
3. Our opportunity for innovation.

The GMENAC report

This was an alternate to Senator Kennedy's attempt to regulate graduate medical education under government auspices. It allowed the private sector to define and deal with the problem of the future supply of physicians. Members of the panel were carefully selected, prestigious and reputable.

Their conclusion was that by 1990 we will have one-third more doctors practicing than today.

There can be no debate about the surplus numbers in Michigan by 1990. But there is a large question as to "need."

Some of the key issues raised by this study are:

1. The role of non-physician providers in this physician surplus
2. Right of U.S. nationals to study abroad
3. Effect of reducing medical school enrollment
4. Relation between manpower and reimbursement.

While GMENAC was not meant as a rigid guideline to restructure manpower, it will stimulate debate. The report states that the majority of specialties, other than primary care, will be from 120 percent to 195 percent over-supplied.

Since this report is the most current and the best data we have, action to decrease medical school admissions and residency programs would certainly be a concern for all Michigan doctors. It is part of the MSMS Council agenda and a special task force has been appointed for the complete study of the report.

We solicit your input.

Federal health planning

The Reagan cost-cutting diet has left local federal health planning in a debilitated state. State health planning centers will be funded through 1982 and then they will be phased out.

Questions for decision are:

1. If federal health planning is eliminated, what is the MSMS position on voluntary health planning at state and local levels?
2. If federal health planning is eliminated, what is MSMS's position regarding the state health planning laws that exist — for example, the State Health Plan and CON?

Health planning has been a part of my professional life since its beginning. Being part of that cumbersome, ruled, and regulated organization, was a learning experience.

For the first time, organized medicine sat in open forum with labor unions, industrial managment, social agencies, local government power, hospital consortia and non-medical health experts. And I learned, as did all the other doctors who took part.

One thing I learned was that I wanted my tombstone to read "Beloved Physician," rather than "Certified Vendor" or "Provider." Another thing I learned was how desirable our system of health care is. Many people want to own it, control it, benefit from it, or exploit it.

I was glad to be a doctor whose only desire was to make it better. And I learned that a doctor, any doctor, sitting on a planning committee could be its most influential voice.

Opportunities for innovation

Lastly, I would like to consider our opportunities for innovation.

1. The state government will have a larger influence on Michigan medicine:

(a) Department of Social Services may receive block grants for Medicaid monies. This might re-open the stalled negotiations of our liaison committee.

(b) Federal planning or not, under Michigan law, the Michigan Department of Health will assume a major role in Michigan medicine. A physician director of the department is a goal we should strive for.

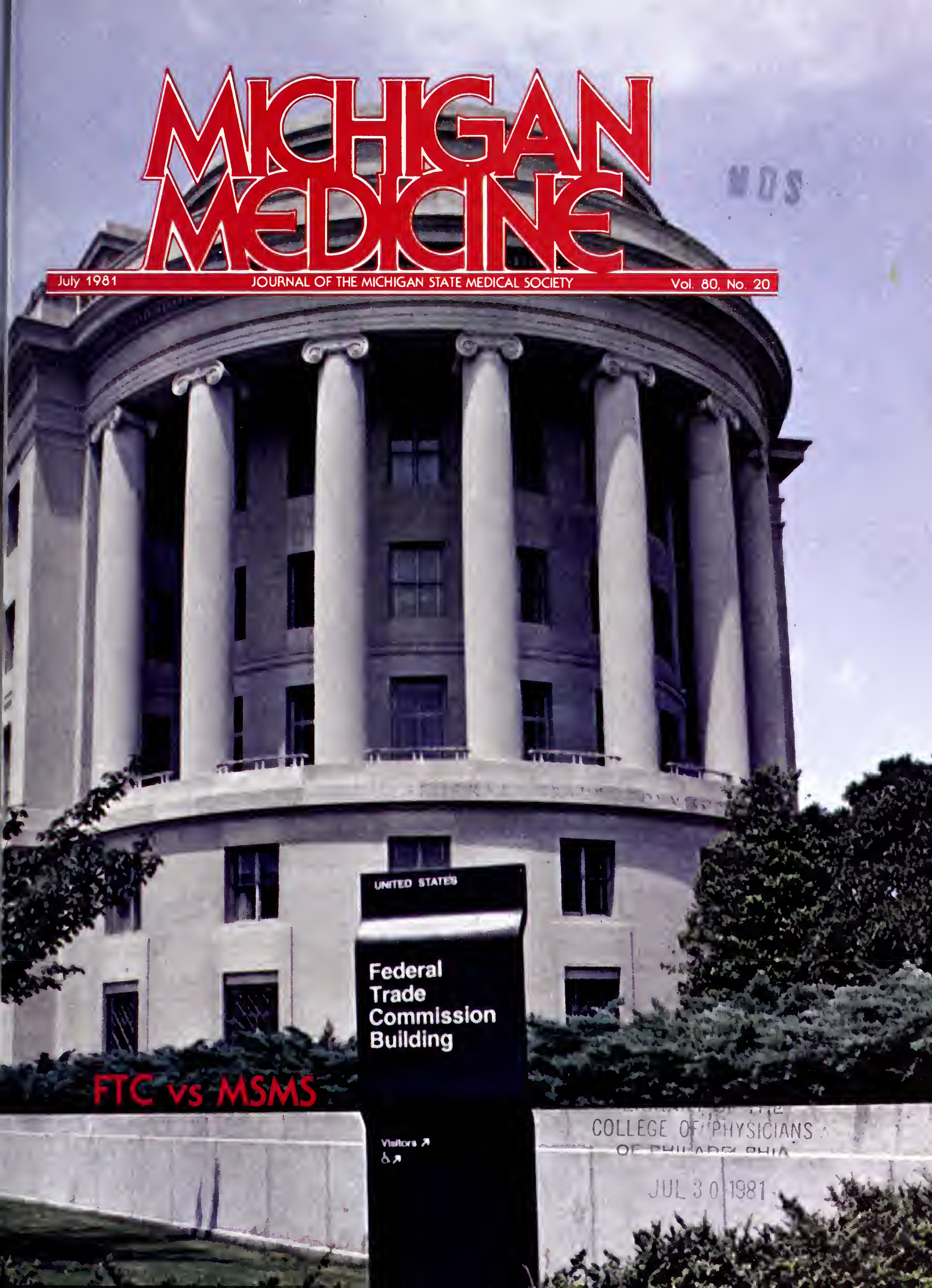
(c) PSROs may be phased out. Doctor expertise in peer review should be a talent we could market or gain alternate funding to support.

Since the theme of the Reagan Administration is pro-competition, let us join him and offer our services at a fair market value. Then let the patient choose and pay for these services with his own money.

MICHIGAN MEDICINE

July 1981 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 80, No. 20

MDS


UNITED STATES
Federal Trade Commission Building
Visitors ↗
♿ ↗

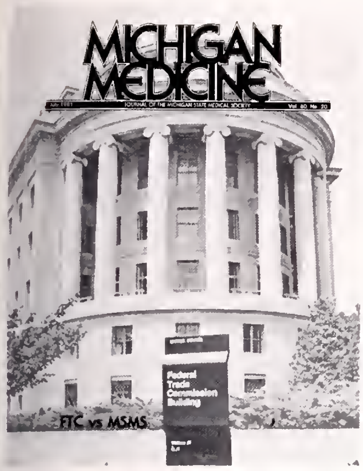
FTC vs MSMS

COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JUL 30 1981

"Hear the Beat of CME"

Stay with the beat of continuing medical education! You can keep current and up to date by attending the 116th MSMS Annual Scientific Meeting, November 17-19 at the Hyatt Regency Dearborn. You will be able to choose from over fifty courses on a variety of subjects and earn up to 18 hours of Category I Credit. The beat of CME goes on — plan now to stay with it.

1981
MSMS ANNUAL
SCIENTIFIC MEETING
November 17-18-19, 1981
Hyatt Regency Dearborn



The Federal Trade Commission headquarters is in a flatiron-shaped building on the corner of Pennsylvania and Sixth Avenues in Washington, DC. It sets the scene for our special report this month on the just-concluded trial of the FTC vs. MSMS. (Photo by Consolidated Graphic, Washington, DC.)

MICHIGAN MEDICINE

July 1981, Volume 80, Number 20

Special report

341 MSMS answered in a strong, straightforward manner to charges by the Federal Trade Commission that MSMS illegally coerced Blue Cross Blue Shield of Michigan and conspired to fix prices. The year-long MSMS/FTC trail that has just concluded provided MSMS with the opportunity to showcase its humanitarian goals and philosophies and to describe its activities on behalf of Michigan physicians. The testimony, on both sides, makes interesting reading. MSMS members who have not been privy to the day-by-day events leading up to and including the trial will enjoy reading the chronology of events and the description of MSMS' stand throughout the ordeal, as described in this month's special report; Shelton Reece and Judith Marr

Features

358 It's time to begin planning for the 1981 MSMS Annual Scientific Meeting

363 Medical Practice Board warns against prescribing for drug-dependent addicts

364 Cost effective medicine; Charles H. Wright, MD

367 Straith Clinic in Southfield may be world's largest plastic surgery hospital; Willah Weddon

371 U-M Clinical Research Center is a resource for all state's physicians; Irving H. Fox, MD

Departments

336 In my opinion; Robert B. Hunter, MD

337 Letters

359 News

360 New members

362 Medical newsfronts

374 Meetings

376 Category I courses

378 MSMS/A

380 Deaths

384 Classified ads

385 Ad index

386 Views; Rhoda M. Powsner, MD, and Sallyanne Payton, LLB

IN MY OPINION

Far too many physicians forget freedom's responsibilities

By Robert B. Hunter, MD, Immediate Past President American Medical Association

This article is excerpted from Doctor Hunter's report to the House of Delegates at the AMA Annual Meeting in Chicago on June 7.

We Americans tend to think first of freedom's opportunities. Certainly such opportunities abound politically, socially, and economically, in our democracy.

And certainly we in medicine have come to enjoy an abundance of opportunities.

We've been given the opportunity to secure a medical education, and to secure additional training in a medical specialty.

We've been given the opportunity to join the staffs of one or more community hospitals, and to bring to our patients the superb clinical care that hospitals help us to deliver.

In our own offices and clinics, too, we still enjoy many of freedom's opportunities, including considerable freedom of choice as to how, when, and to whom we provide our services. And society has seen fit to reward us in proportion to our long years of education and training, and because of what all this means to our patients.

But it seems to me that far too many physicians in this country have forgotten that these *are opportunities* given to us, and not inalienable *rights* vested in us.

Far too many physicians have also forgotten that freedom *does have* its obligations, larger obligations that we owe to all of society.

And far too many physicians have forgotten that we will continue to enjoy freedom's opportunities only to the extent that we continue to fulfill our obligations to society.

These larger obligations are exemplified by the positive steps taken by this House, this federation, and by other organizations as well, in areas such as cost effectiveness, medical education and medical ethics, and in the betterment of public health.

These larger obligations also are exemplified by membership development programs at various levels of the federation, and by the steady expansion of the membership franchise in this House of Delegates.

Because it is through this House and the AMA, and through our county and state medical societies, that all of medicine *can* come together to *collectively* recognize and *collectively* fulfill our larger obligations to society. And these obligations ultimately *do fall* to each physician.

When I entered medicine, my father told me I was not a slave of the public but that I *was* a servant of the public. I can think of no better message to leave to the physician who may have forgotten freedom's obligations.

Serve your patients.

But serve your profession and your federation as well.

In so doing you also *will* serve all of society, and serve it well.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairma
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
John R. Ylvisaker, MD, Pontiac

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $20.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. ©1981 Michigan State Medical Society.

LETTERS

Medical assistants

In the May 1981 issue of *Michigan Medicine*, an article, "The Certified Medical Assistant Helps Meet Ambulatory Care Needs," by Carol Campsmith, RN, CMA-AC, MA, of Kalamazoo Valley Community College was published and is of most interest to AAMA. It is an excellent article and AAMA, State of Michigan, is most appreciative to both Ms. Campsmith for writing it and to you for publishing it.

I have written to Ms. Campsmith requesting her permission to use copies of her article for AAMA's use.

Thank you once again for seeing the need for this excellent article.

Shirley A. Licking, CMA-A
President, Michigan Branch, AAMA
901 Harris Bldg.
Jackson, MI 49201

MSMS and the DMH

In the March, 1981 issue of *Michigan Medicine*, John R. Ylvisaker, MD, had an article entitled "My Goal: Forging Formal Links with Groups which Share our Destiny." It describes certain "links which can enhance the ability of MSMS to affect our practice environment positively." Among these nine links he includes medical specialty societies, Michigan Hospital Association, the Department of Public Health, third party payors, etc.

I was very surprised to see that within the MSMS organization there is no organized committee or body to touch base with the Department of Mental Health. The DMH policies and procedures affect considerably the practice of medicine of many physicians. These are not only the physicians who are in the employ of the mental hospitals, facilities for the developmentally disabled, or community mental health agencies. At the present time, with the adopted goal of DMH being to place these patients in the community, it is obvious that most of the practicing physicians will be involved in the treatment of this population.

I think that the MSMS and DMH should have an input in each other's functions, and it appears to me that MSMS should make the first move.

Isak O. Berker, MD
Davison

AMA-ERF checks

I was delighted to receive the check in the amount of $18,353.33 from James E. French, MD, who represented us at the (MSMS) annual meeting. It is highly rewarding to find increasing support for this fine program in support of medical education.

Knowing their strong support, I have also conveyed our appreciation to Mrs. Robert J. (Donna) Chase and the (MSMS) Auxiliary. I understand their prominent role in securing the funds each year.

Please accept our sincere thanks for what has been made possible by many contributions throughout the state.

John A. Gronvall, MD
Dean, Medical School
University of Michigan
Ann Arbor

Fluoride

Among the "scientific information" which Dr. Margolis claims is the responsibility of Public Information Committee of the MSMS (Feb. *Michigan Medicine*) surely is up-to-date news of what has been developed in recent research into long established problems.

Tooth decay has been getting worse for years and if the use of fluoride to combat it fails to overcome opposition to its use, most likely it is because of the existing obsession with fluoridation of water systems, abhorrent to vast numbers, and failure to give adequate attention to more selective modern methods. People do not like its indiscriminate infusion into their drinking water for the whole of their lives. They are instinctively right.

What they do not know, and are not told enough about, is that fluoride works through becoming integrated into the teeth and not just by being washed over their surface. To become a part of their composition, the fluoride must be absorbed during the period of their growth until they have fully erupted with the protective enamel in its final state. This process by modern approved methods is achieved by giving the child a daily drink of 200 ml. of milk containing 1 mg. of fluoride. If milk is not acceptable or available fruit juice can be used instead but will not of course supply the protein, calcium and vitamins which are the milk's content.

The Borrow Dental Milk Foundation has evolved a system to cover a year of 365 days so that school holidays are effectively included. Necessary plant for mixing the fluoride and milk, and manner of distribution have also been devised. The Foundation does not itself sell either milk or machinery but will advise upon the setting up of pilot schemes where suitable.

Eight countries have already embarked upon projects. The latest is in Louisiana where the State University Dental School is treating 500 school-children volunteers side by side with a control group. In the U.K. the milk method has been operating under Glasgow University for five years. Results reported by Dr. K. W. Stephen at dental conferences in Paris and Hamburg aroused much interest.

Details may be had from the Borrow Dental Milk Foundation, Padnell Grange, Cowplain, Portsmouth, Hants., England.

Phyllis Deakin
1 Burnside
Waterlooville
Hants, P07 7QQ
England

Feelings vs

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ⒸⅣ, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® Ⓘⓥ diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient
Contraindicated: Known hypersensitivity to the drug Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy, gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy
Dosage: Individualize for maximum beneficial effect *Adults* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b i d to q i d , alcoholism, 10 mg t i d or q i d in first 24 hours, then 5 mg t i d or q i d as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t i d or q i d , adjunctively in convulsive disorders, 2 to 10 mg b i d to q i d *Geriatric or debilitated patients* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated (See Precautions) *Children* 1 to 2½ mg t i d or q i d initially, increasing as needed and tolerated (not for use under 6 months)
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

This publication is available in microform.

University Microfilms

University Microfilms International

Please send additional information
Name ____________
Institution ____________
Street ____________
City ____________
State ________ Zip ________

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London W1N 7RA
England

SPECIFY
ZYLOPRIM®
(allopurinol)
THE ORIGINAL ALLOPURINOL

ZYLOPRIM
U4A

Two convenient dosage forms: 100 mg (white) and 300 mg (peach) Scored Tablets

ZYLOPRIM
C9B

Tablets imprinted with brand name to assist in tablet identification.

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

SPECIAL REPORT

MSMS Council votes to appeal decision that MSMS violated anti-trust, fixed fees

The official decision of the Federal Trade Commission administrative law judge in the case of the FTC vs. MSMS finally arrived in MSMS headquarters offices July 6.

Announced with a form letter date June 26, the decisions consists of 85 pages of findings of fact, legal discussion and orders.

It does just as the FTC press release of June 30 says it does — it rejects MSMS arguments that the medical society is exempt from anti-trust scrutiny, or, in the alternative, did not violate the anti-trust laws or Section 5 of the FTC Act.

MSMS actions, according to the FTC press release, allegedly deprived third party payers of the benefits of competition among physicians and deprived consumers of the benefits of third party, independently determined, reimbursement or health care costs containment efforts.

However, the judge's decision is not as harsh on MSMS as was the original consent order the FTC tried to get MSMS to sign in early summer, 1979.

MSMS refused to sign that consent order and chose instead to go to trial with the FTC to explain and clarify the health care industry to the FTC.

The forthright and clear manner in which MSMS described its activities with BCBSM is evident in the testimony of that trial. The lengthy article which begins on the next page and takes up much of this issue is printed here to aid MSMS members in knowing how well their aims and purposes were presented to the judge.

He appears to have based his decision on documentary evidence rather than witnesses' testimony during the trial, however.

It has been a year now since the trial commenced. The decision has come down, and it is not only antithetical to MSMS purposes and goals but also it is a prior restraint on MSMS First Amendment rights to free speech. Thus, the MSMS Council has voted to appeal the decision.

Following is the official MSMS response to the initial FTC news release on the administrative law judge's decision. On page 354, the orders of the judge's decision are duplicated verbatim. Should MSMS have acquiesed to the judge's decision, these are the conditions it would have had to meet.

Here is the text of the MSMS' first response, as it also appears in a special edition of *Medigram* dated July 2, and as it was released to the press that day:

The Michigan State Medical Society voted July 2 to appeal a Federal Trade Commission Order that it can no longer initiate or participate in health care cost containment talks with the state's Medicaid program and all health insurers.

MSMS took this action without the opportunity of reviewing the official FTC order. The FTC procedure is to issue its press release before mailing the order to parties involved. The order was mailed June 30, according to FTC.

The 9,700 member physician organization's Council (board of directors) was unanimous in this decision to respond to the reported FTC gag order, according to James D. Fryfogle, MD, president of MSMS.

"The FTC Administrative Law Judge has directed that MSMS can respond only when asked for advice by third party payors such as insurance companies and government agencies. This is tantamount to removing physician knowledge and experience from efforts to contain health care costs," said Doctor Fryfogle.

"Without physician involvement, there can be no containment of costs," continued Doctor Fryfogle.

Doctor Fryfogle is a Southfield thoracic surgeon who chaired the first Medicaid-MSMS Liaison Committee in 1972.

The gag rule would specifically end a nine year physician liaison with the Department of Social Services which was directed toward improving benefits and the availability of physician care. Doctor Fryfogle credited the Liaison Committee's effort with achieving the highest physician participation in any state Medicaid program in the nation. The committee was also praised in February of this year by Governor Milliken who expressed his appreciation to a representative of MSMS, Doctor David Siegel, for his "untiring dedication" to the Medicaid program and the people it serves.

This ruling would also prohibit MSMS from responding to a current request to aid the unemployed. The UAW has sought MSMS/statewide support of a plan to provide lower cost medical care for workers who have exhausted their health insurance benefits.

MSMS questions the jurisdiction of the FTC over the professions and the delivery of health care. The MSMS position is supported by the fact that the issue is before the U.S. Supreme Court. A bill introduced by Ohio Congressman Luken (Democrat) also is presently before Congress to remove the professions from FTC jurisdiction.

The Order places MSMS in a difficult legal position because the recent state Medicaid appropriation law directed the MSMS to join Medicaid and the Legislature in developing cost effective alternatives within the present Medicaid program.

Fryfogle said, "This certainly seems in conflict with the FTC Order."

Further, the Michigan Legislature has directed Blue Cross Blue Shield of Michigan to develop further health care cost containment programs with consultation from physicians and hospitals.

"We face a dilemma. On the one hand the state government is telling us to have discussions with Medicaid and Blue Shield, and on the other hand the Federal government is telling us we cannot," Doctor Fryfogle said. "We apparently are going to get into trouble one way or the other, so it might as well be on the side of what is best for our patients and the State of Michigan."

During FTC trial, MSMS staunchly upheld MDs' role in medical cost containment

By Shelton Reece and Judith Marr

In November, 1978, the U.S. Federal Trade Commission initiated actions that culminated in a landmark legal case against Michigan State Medical Society.

The case, which has been extremely time-consuming and expensive for all concerned — including the nation's taxpayers who ultimately pay for such government actions — began as part of a national investigation of alleged physician control of Blue Cross Blue Shield plans.

The FTC originally alleged that MSMS conspired with its members to restrain trade and also that MSMS illegally negotiated with the Blues. As the months went by, the charge evolved to one of price-fixing.

MSMS vigorously denied all charges and fully defended the case, by countering that physicians are uniquely qualified to have meaningful input in the health care field.

"The FTC through this case is attempting to take MSMS out of the business of discussing cost containment with third party payors, such as Blue Cross and Blue Shield," said a *Michigan Medicine/Medigram* article of August 10, 1979. "MSMS feels strongly that it has a role in promulgating effective and efficient cost containment modes of health care in Michigan."

Here's what happened

Following is a brief explanation of events which preceded the FTC's charges against the Society, and of the trial itself.

The forerunner of Blue Cross-Blue Shield of Michigan (BCBSM) was formed by physicians in 1939.

But by the 1960's, physician control of BCBSM was strongly attacked by the United Auto Workers Union and others. Michigan physicians had decreasingly fewer opportunities to make meaningful contributions to BCBSM subscriber programs. In 1970 MSMS's House of Delegates resolved to totally disengage from BCBSM affairs. Then, in 1974, frustrated, and regretting its distance, the House created a Third-Party Carriers Committee to address the many problems it felt were caused by lack of physician input into BCBSM's coverage of patients' medical care costs. Named chairman of that committee was Donald R. Crandall, MD, Muskegon surgeon.

"It was our purpose to set up some kind of liaison or official communication channels between MSMS and BCBSM," said Doctor Crandall in courtroom testimony during the MSMS/FTC trial.

The MSMS House of Delegates resolved that the Society's Third Party Carriers Committee should negotiate with BCBSM on behalf of MSMS members. If the Committee could not accomplish its objective, it was empowered to recommend statewide non-participation in BCBSM by MSMS members, take legal action, and make other appropriate moves.

The Committee held several meetings during the following two years with representatives from BCBSM, Michigan Department of Social Services, Medicare and other prominent insurance carriers to try to establish a uniform claims form and coding system, regionalization of fees, automatic update of physician profiles and screens, fee and utilization review, and specialist/generalist fee differentials. Those endeavors met with almost no success. The Blues, in particular, were not interested in physician input.

"Blue Shield never really offered us a claim form to look at and seemed to be dragging their feet on the process," testified Doctor Crandall of this period in the MSMS negotiating team's history.

"We reached an absolute impasse because of Blue Shield's unwillingness to go along with the program of what everyone else thought was a good deal." This was about MSMS, Medicare, Medicaid, private insurance carriers' and BCBSM talks on the uniform claim and coding system.

"You can imagine the frustration of the committee," Doctor Crandall testified about one incident when the Blues agreed to work out a statewide screen and reneged, and another when BCBSM agreed to helping physicians update profiles annually and then said it wouldn't do so.

In 1976, the House expanded the Third Party Carriers Committee into an MSMS member/staff Division of Negotiations. Among the many charges the Division had were to: Identify specific problems amenable to negotiations, devise action plans, coordinate all Society negotiating activities, educate and assist members in the use of negotiation techniques, collect from all physicians non-participation proxies which were held in escrow at MSMS for execution only in the event of failure of negotiations, and to formulate and/or negotiate participation agreements with BCBSM to eliminate reasons for non-participation.

Negotiations unsuccessful

By late summer 1977, it was apparent that MSMS's negotiation efforts were not successful. Members were faced with three newly-proposed BCBSM health care plans to which they had made no contributions and which the majority thought improperly rationed health care and discriminated against nonparticipating physicians and their patients.

Features of the BCBSM plans were: a Target Limitation on Expen-

continued on page 344

he FTC headquarters in Washington

ditures (TLE) — designed to limit payouts to physicians; a Vision Care Program which would pay 80 percent of a bill from participating physicians, but only 60 percent from those with nonparticipating status; and a Hearing Care Plan — designed to pay 100 percent of a reasonable charge by a participating doctor but nothing to nonparticipating physicians.

To MSMS' astonishment, when the Blues announced their new plans, they cleimed MSMS contributed to and approved of the plans. MSMS informed BCBSM it was very unhappy with BCBSM's announcement.

The BCBSM response was to claim it had no responsibility to tell MSMS members what MSMS thought, as MSMS was perfectly capable of doing that on its own.

"It appeared to me, in midsummer, '77, that BCBSM was going to tell MSMS to 'bag it,' and they did," remembers MSMS Legal Counsel A. Stewart Kerr, Detroit.

"The Division of Negotiations and leaders of the Society were unhappy about a service that distinguished, and made services to the subscriber differ for patients that chose a nonparticipating, rather than a participating, physician," testified Doctor Crandall.

"That is, you put the subscriber at an economic disadvantage, if they wish to select a nonparticipating physician, and in that way you are directly influencing their free choice of physicians." This, pointed out MSMS lawyers during the trial, directly violated the BCBSM enabling act, which prohibits the Blues from interfering in the physician-patient relationship.

Special House meeting

So, on October 26, 1977, the MSMS Council called a special House meeting to make policy decisions on those three new BCBSM reimbursement programs. The Division of Negotiations recommended and the full House approved resolutions that:

1) **The House recommend that** all physicians in Michigan withdraw their participation from BCBSM;

2) **The House instruct the Division** of Negotiations to begin direct dialogue with key BCBSM subscriber groups to provide medical contributions to service benefit programs;

3) **The House instruct The** Council to urge Michigan businesses and industrial employers to seek MSMS advice in selecting carriers for health insurance programs;

4) **The House authorize The** Council to recommend that membership no longer complete BCBSM claim forms; and

5) **The House authorize The** Council to investigate a model health insurance plan to replace the BCBSM 94000 Plan offered MSMS members.

After that special House meeting in October, 1977, particular efforts were made by MSMS leaders concerning the first recommendation, i.e., to urge physicians to departicipate from BCBSM.

However, the departicipation effort was unsuccessful. By mid-December, 1977, only about 1,700 physicians had sent letters to BCBSM indicating their departicipation. Many of those were nonparticipating providers and might not have participated in any event. By the end of 1977, BCBSM actually had experienced a substantial gain in the number of physicians (1,000) who signed participating agreements.

"Many physicians approached me after the vote. They said they voted for the position of the State Medical Society to departicipate, but they personally were not planning on doing that because of their contractual arrangements with a hospital," testified Doctor Crandall.

The departicipation idea evidently did gain the attention, at least, of BCBSM. Late in 1977, BCBSM indicated an interest in trying to work out differences with MSMS. Three days before the TLE reimbursement policy was to go into effect, BCBSM and MSMS drafted an approved letter of understanding; in effect, agreeing to negotiate their problems.

In April, 1978, the MSMS Committee on Negotiations met with BCBSM representatives to develop an agreement for negotiating. A document was prepared and approved by the MSMS House in its May meeting. That agreement was approved by BCBSM Board of Directors in May, 1978. It contained these four "principles" as goals for future negotiating efforts:

1) **An effective cost contain**ment program as an alternative to th TLE Program unilaterally propose by BCBSM in July, 1977;

2) **An effective service benef** program — a mechanism for more e fectively and quickly paying phys cians;

3) **A specific reimbursemen** policy incorporating service benef and cost containment principles;

4) **Plans which do not dis**criminate in reimbursement betwee participating and non-participatin physicians.

In January, 1979, a draft agreement pertaining to the four principles was reached by MSMS/BCBS teams. However, MSMS Council requested that Society members b polled for their reaction to it. Approximately 70 percent of the member disapproved the proposed agreement That prompted MSMS's House to reject the agreement.

"It is my opinion that there wer primarily two reasons it was defeate at that meeting," testified Docto Crandall.

"One was that this agreemen outlined a cost containment program Each and every factor of it was no completely defined and there wa some judgment as to how BCBS would administer it. And the physicians that were addressing this issu and trying to make a decision on it that is the leadership of the society had past experience with BCBS and quite frankly distrusted them.

"I was unable to convince th majority of the delegates that Blu Cross would honor not only the letter, but the spirit of the agreement though I was confident of this.

"The second reason was that a that time we had an inquiry fro FTC into our activities with BCBSM The entire atmosphere at that Hous of Delegates was a very oppressive type atmosphere. A lot of the physicians wished not to get into any kin of agreement with anybody becaus of this FTC investigation into our activities."

FTC subpoenas MSMS

In November, 1978, FTC subpoenaed MSMS concerning its October, 1977 special House of Delegates meeting and subsequent educational efforts concerning physicia participation with BCBSM.

The cast of characters:

Witnesses for MSMS:

Doctor Crandall

Doctor Griffin

Doctor Siegel

photo
not
available

Doctor Leffler

Doctor Sloan

MSMS legal counsel:

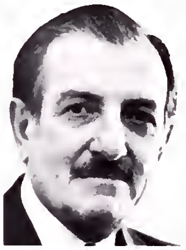
Mr. Kerr

Mr. Sankbeil

The judge:

Judge Howder

Witnesses for FTC:


Mr. Glasser

Doctor Hayes

In April, 1979, depositions were aken from two key MSMS officials nvolved in the special House meeting: Doctor Crandall and Ernest P. Griffin, Jr., MD, Flint radiologist, and ormer MSMS Council Chairman.

The FTC filed a formal complaint against MSMS in July, 1979.

Prior to filing, FTC attempted o get MSMS to sign a Consent Decree which would have prohibited physicians from collectively negotiating on cost containment and aspects of reimbursement with all third-party payers, including the government and BCBSM.

FTC charges

MSMS would not agree to the Consent Decree, and its attorneys negotiated at length with the FTC in an unsuccessful effort to obtain a decree protecting what MSMS saw as organized medicine's First Amendment rights. But the commission filed charges against MSMS to be heard by an FTC Administrative Law Judge in Washington. The FTC's charges read, in part, as follows:

MSMS is organized for the purpose, among others, of guarding and fostering its members' material interests and insuring that its members receive fair remuneration for services rendered. By virtue of such purposes and activities, MSMS is a corporation organized for the profit of its members;

MSMS has restrained competition among physicians in Michigan by acting as a combination of at least some of its members, or by combining or conspiring with at least some of its component societies or with at least some of its members to: Fix, stabilize or otherwise tamper with the fees which Michigan phsyicians receive for their services; engage in concerted action to restrict, regulate, impede or interfere with health care cost containment or reimbursement policies of BCBSM or Michigan Medicaid; engage in concerted negotiations with BCBSM with respect to health care cost containment or reimbursement policies of BCBSM;

MSMS has engaged in acts and practices in furtherance of the combination and conspiracy including among other things: Soliciting and collecting "proxies" from its members which enable it to collectively terminate such members' written agreements with BCBSM or Michigan Medicaid, if BCBSM and Michigan Medicaid did not adopt reimbursement policies acceptable to respondent: Engaging in concerted actions against BCBSM which include, among other things, organizing a concerted refusal by its members to deal with BCBSM; engaging in negotiations with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM; entering into an agreement with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM.

The purpose, tendency and effect of the combination and conspiracy and of the acts and practices has been to: Restrain competition among physicians in Michigan; fix, stabilize, or otherwise tamper with the fees which Michigan physicians receive for their services; deprive third party payers of the benefits of competition among Michigan physicians; deprive subscribers and consumers of the benefits of third party payers' independently determined reimbursement policies or health care cost containment efforts.

On August 13, 1980, Kerr, Russell and Weber, legal counsel for MSMS, filed a motion asking for clearer language in two portions of the FTC complaint. The portions in question involved: (1) MSMS's purposes; and (2) the charge that MSMS allegedly restrained competition among Michigan physicians.

Their motion was denied. On September 17, counsel filed MSMS's obligatory responses to FTC charges.

MSMS responds

Briefly, the responses stated that because of economic factors indigenous to the health care system in the US, and particularly in Michigan, traditional antitrust concepts should not be applied to this case; that the alleged illegal behavior of MSMS is governed by the rule of reason, not per se violations, and that FTC must prove the anticompetitive purpose and effect of MSMS's conduct; FTC cannot prove their charge of an illegal conspiracy; MSMS's activities in relation to Michigan Medicaid are exempt from antitrust scrutiny because of MSMS's right to petition the government for relief; the McCarran-Ferguson Act dealing with acts within the business of insurance exempts MSMS from antitrust liability; MSMS is not subject to FTC jurisdiction; the acts and practices of MSMS are not in and do not affect interstate commerce.

"We want more money"

The trial began in Washington on June 4, 1981.

During the trial, the FTC charged that the effect of MSMS's actions had been to fix, tamper with, or stabilize physicians' fees.

The Commission's lawyers opened with a statement that MSMS's intent was "we want more money." "With that, it became clear,

"With that, it became clear, for the very first time, the FTC . . . charge was conspiracy to fix prices," recalls Mr. Kerr.

"We were prejudiced all the way to trial by their not being forced to state their charge articulately," he continues. "Until that time, we could not really get them to be specific."

Before there could have been price fixing violations, according to law, conspiracies among physicians would have to have existed.

MSMS's counselors argued that the FTC had to prove a conscious commitment by two or more persons, or entities, to participate in a conspiracy with the purpose of price fixing.

Additionally, they said, proof had to be established that there was some restraint on competition and, if such restraint had existed, whether it was unreasonable. (Unreasonable is determined here by the signficance of restraint in context of the particular industry involved.)

Doctor Crandall testified that there was no MSMS price-fixing conspiracy.

Following the MSMS House of Delegates' disapproval of the MSMS/BCBSM negotiating groups' agreement of principles, and as the FTC was subpoenaing MSMS leaders, MSMS and BCBSM formed a new Physician Liaison Committee. Doctor Crandall was a member, as were BCBSM consumer board members and an osteopathic physician.

"We were simply trying to develop a stage where we could sit down and talk," testified Doctor Crandall. "No MSMS representatives made any threats to BCBSM," he said.

"We had concerns about developing an effective, efficient, cost-containment program for the State of Michigan. And it was our decision to work in an atmosphere of problem-solving to develop some kind of a program that would do that."

During the course of the Liaison Committee's discussions, did you personally, as an MSMS representative, he was asked during the trial, ever make any demands for a specific fee-for-service or specific dollar amounts, anything of that nature, of BCBSM representatives?

"No, we did not," he replied.

MSMS's attorneys contended that the FTC did not prove the above and that the evidence conclusively established that no conspiracy existed; that the Society had no anticompetitive intent, and that there was no anticompetitive effect.

Two outstanding health care economists, Frank Sloan, PhD, Vanderbilt University, and Keith Leffler, PhD, University of Washington, Seattle, were called by MSMS as expert witnesses during the trial. They told the judge that in the Michigan health care delivery environment, MSMS's conduct was the expected human reaction and the most desirable economically. Their only criticism was that Michigan physicians did not band together to obtain results which they felt would have had a procompetitive effect on the Michigan health care market.

The economists' testimony established beyond question the credibility of the testimony of MSMS witnesses, who said they had no intent to fix prices or obtain any other anticompetitive effect.

Such intentions were never in the minds of MSMS representatives, said Doctor Crandall and another key MSMS witness, David Siegel, MD, Lansing, then chairman, MSMS Medicaid Liaison Committee.

The Society's mission was to be a voice, they said. It was a voice objecting to ill-conceived, unfair proposals and actions which MSMS saw as lowering the quality of health care, possibly injuring patients, restricting physicians' professional judgments, and breaching contracts.

What MSMS argued

Here are highlights from the MSMS attorneys' analysis and discussion of the trial's evidence of record:

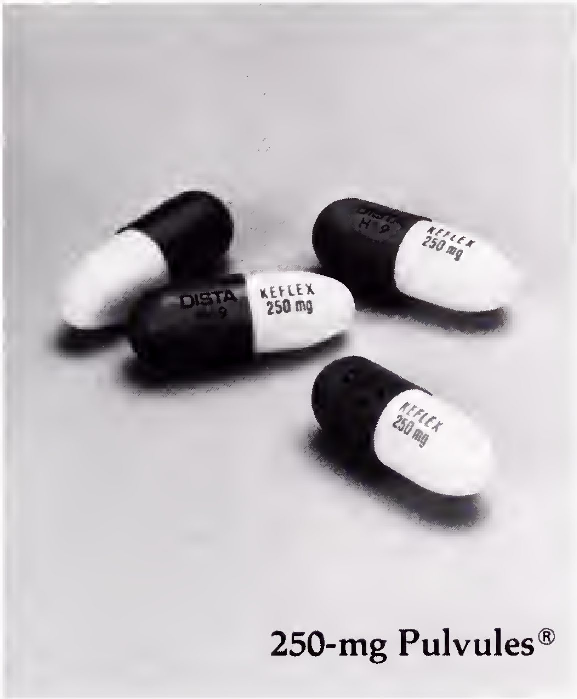
• MSMS's Negotiating Committee was formed in 1974 for the purpose of establishing a liaison communication mechanism between it and BCBSM, because MSMS wanted to have the ability to relate concerns and desires to BCBSM.

"It is apparent that BCBSM felt input and advice was critical, because it appointed Louis R. Hayes, MD, to a position with responsibilities for relating and communicating with organizations of providers, including the Society," said MSMS Counsel. Also, they surmised, BCBSM evidently attached importance to knowing MSMS thinking because during Doctor Hayes's employment at the Blues, 1968-1980, he was an alternate delegate from Wayne County to the Society's House of Delegates.

• The fact that MSMS's negotiating committee desired, and

continued on page 348

easy to take



250-mg Pulvules®

Oral Suspension
250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes

Pediatric Drops
100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

arranged for, discussions between BCBSM, Michigan Medicaid, and the Health Insurance Association concerning a uniform claim form, was a legitimate activity. It was not initiated for any anti-competitive effect.

It was not initiated for any anticompetitive effect.

Doctor Hayes himself testified MSMS wanted a uniform claim form as a cost containment measure, and that there were good reasons to have a uniform form and coding system.

"A uniform coding system," he said, "provided a high rate of accuracy by the physician's office staff in recording the service performed, and would alleviate BCBSM's need to have people read, and correct, claim forms. It also would reduce the delay in BCBSM payments to subscribers."

Doctor Hayes admitted that at the outset of the discussions, all the parties agreed a uniform claim form and coding system were something that should be.

BCBSM said the development of the form and system was achieved in the context of discussion, in an environment of liaison, and was not the result of negotiation or antagonism between BCBSM and MSMS.

- **There was no anticompetitive intent or purpose behind the Negotiating Committee discussing the issue of a statewide screen during 1974 to 1976, and there could be no anticompetitive effect because the statewide screen was not initiated pursuant to those discussions.**

Doctor Hayes admitted that any time MSMS representatives discussed the possibility of BCBSM implementing a statewide screen, they *always* stated that MSMS did not want BCBSM to increase its overall dollar payout to physicians in the process.

It is clear from the record that the reason BCBSM did not implement a statewide screen during 1974-1976 was not that it disagreed with the legitimacy of the positions stated by MSMS, but rather because of its own self interest, said MSMS lawyers.

"Is it accurate that one of the BCBSM concerns in going to a statewide screen," asked MSMS Counsel William Sankbeil of Doctor Hayes, "was that if the statewide screen would be lower, and if the reimbursement to Area 1 doctors was important to BCBSM, they might lose some formally participating doctors?" (Area 1 of Southeast Michigan had the largest concentration of BCBSM subscribers.)

"That's true," answered Doctor Hayes.

BCBSM did state it would reconsider implementing a statewide screen if MSMS could guarantee there would be no decrease in formal participation in Area 1. In response, the Negotiating Committee told BCBSM it could not guarantee any level of participation in Area 1 because participation was purely a matter of individual decision on the part of each physician.

- **There was no anticompetitive intent or purpose behind the collection of the powers of attorney in 1976. There was no anticompetitive effect because the powers were not exercised.**

MSMS Counsel argued that the powers of attorney were contemplated to be an opinion survey of Society members to see how they felt about the Department of Negotiations' activities. BCBSM, Doctor Hayes testified, never believed there were enough powers of attorney collected and signed to be worried about. And BCBSM continued to feel it was necessary to continue relating to MSMS after MSMS called for the powers of attorney. This was the only request MSMS ever made for powers of attorney, and these powers of attorney were never exercised. There is no evidence these powers of attorney were collected for anticompetitive purpose or that their collection had an anticompetitive effect.

MSMS attorneys said that BCBSM's real motive behind their participating/non-participating physician differentials was to force all physicians to become formally participating and thereby to increase its dominance and control of physicians.

- **The Society's activities leading up to the special House of Delegates meeting merely amounted to the dissemination of information, and BCBSM's actions prompted the call for the meeting; the resolution passed at the meeting was nothing more than an official policy statement of MSMS and was not an individual commitment by any physicia attending the meeting; and th events and activities occurring afte the meeting were not prompted b any anticompetitive purpose or intent and had no anticompetitive e fect.**

Doctor Crandall testified that th MSMS House of Delegates' resolutio urging individual physicians to departicipate from BCBSM was nothin more than the establishment of th official policy of MSMS and any action in response to it was up to th individual physician's discretion Additionally, Doctor Hayes testifie that he never believed the House o Council actually and truly represented individual physicians i Michigan.

Michigan's systems unique

An important part of MSMS arguments were those describing th unique aspects of health care delivery in Michigan, as well as th unique presence and power of th UAW and BCBSM, factors indigenous to Michigan.

Those aspects and characteristics, MSMS legal counsel emphasized, make MSMS's conduct eve more understandable and appropriate.

- **The existence of the powerfu UAW, touting its prejudicial, incorrect and myopic views of health car in general, and physicians in particular, maintained MSMS counsel was a disrupting influence in Michigan.**

The UAW demanded and designed full service benefit health car and wanted this product with the ai of subsidization by physicians an others. A witness in the trial, calle by FTC counsel, Melvin A. Glasser director of the Social Security Department, United Auto Workers, admitted that the UAW's goal is to hav comprehensive full service benefi health care for its members.

The UAW, noted MSMS lawyers has BCBSM underwrite the healt care benefits for the overwhelmin majority of its plans in Michigan, a it believes BCBSM has cost advantages over private insurance carriers In Michigan, BCBSM administrate well over 70 percent of the UAW health benefit plans.

continued on page 35

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg., Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When **impotence** is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

"The UAW since 1963 has gone its merry way in determining, designing and developing benefit packages and having BCBSM underwrite them," wrote the MSMS legal counsel in its findings of fact and conclusions of law.

"Of course, even with the cost advantages the UAW obtains by using BCBSM, there will still be remaining dollars that must be paid by someone. The UAW realizes that it can only obtain so much from the employers with whom it bargains, and therefore attempts to develop plans that will give it full service benefits, but for as low a cost as possible.

"One mechanism that it came up with is the discrimination between participating and non-participating physicians . . ."

The UAW also, argued legal counsel, is firmly committed to the principle that the people who pay for physician services (the UAW and employer) have the right to determine collectively the amount by which physicians can increase their fees and incomes. The UAW has decided it will tell BCBSM what and how it will underwrite the health care plan and tell the physicians the amount in which they will subsidize the plan.

The UAW has tremendous influence and control of BCBSM simply because of the volume of business it directs to BCBSM, said MSMS lawyers. Doctor Hayes testified that 80 to 85 percent of the total number of persons covered in Michigan under BCBSM's national account type programs are employees of automobile companies and approximately 35 to 40 percent of all persons covered by BCBSM for any type of contract are automobile employees.

- **MSMS's lawyers argued that the UAW takes a contemptuous view of and does not respect physicians.**

"A statement I make as a professional person," testified Mr. Glasser, "is that as a union we will oppose fee-for-service in any way we know how.

"Many of us are convinced the cottage industry of medical care is at the root of many of the ills in our health care system. I hope you understand we have a number of plans and programs in progress to move in an evolutionary way from fee-for-service to other means of reimbursement to providers."

What he means about medicine being a cottage industry, clarified Mr. Glasser, is "the type of industry where an individual practices alone, with no accountability for his decisions or his treatment, with no reporting except on a payment and claims basis, where there is lack of planned access to the myriad of complementary skills necessary to treat most serious conditions, where the individual operates in isolation with a medical scientific discipline that requires the highest integration of skills.

"In other words," concluded Mr. Glasser, "it is comparable to the women of England who stayed at home in their cottages and sewed garments and eventually turned them in to be reimbursed."

MSMS Counsel also stated that it cannot be disputed that the reason the UAW wanted the formally participating/non-participating differentials in the Vision and Hearing Care Plans was to force physicians to become formally participating and thereby gain control over them. Mr. Glasser testified that these plans constituted the first time a benefit plan for UAW members had been developed where there was a differential in the payment between participating and non-participating physicians.

"Is it not also true," asked MSMS Counsel Sankbeil of Mr. Glasser, "that you believe this participation/non-participation would be of substantial encouragement to participation because providers who would not participate would have to recognize they are removing themselves from the largest single source of new income they would get in the state, the UAW benefits?"

"Correct," answered Mr. Glasser.

Michigan's unique economy

Furthering their arguments and descriptions concerning the factors that are indigenous to the health care system in the US, and particularly in Michigan, and BCBSM's power, the Society's counsel called the two health care economists, Doctor Leffler, and Doctor Sloan, as witnesses.

Their testimony made it clea that Michigan's health care system i different from traditional industrie and businesses and even from healt care generally in the US.

Some of the expert witnesses analysis of the system as it existe prior to the October 26, 1977 meetin are:

1) Health care delivery generall is distinct from traditional industrie and businesses;

2) The extent of subsidization i physicians' services in the form o third party payment by insuranc companies and others makes th physician services market uniqu from traditional businesses;

3) Full service benefits, as opposed to partial service benefits, distinguish Michigan from other healt care markets;

4) The UCR concept, wher physicians are paid the lowest o their actual recorded fees, their usua fees as recorded by BCBSM, and thei customary fees, actually is unusual;

5) Per case participating, whic is unique to BCBSM, is a good concept and was not used by anyone fo any anticompetitive purpose in Michigan;

6) Containing health care cost is a complex question and, in Michigan, physicians could not be th source of undue cost increases. Th economists thought BCBSM's TL cost containment approach was ill conceived.

Some other major factors whic distinguish BCBSM in its relationship to the medical market place in Michigan as compared to the Blue's plans in other states are:

7) The Blues had 58 percent o Michigan's physicians as participating physicians. 1,000 physicians became participating MDs from October, 1977 to April, 1978; this percentage grew to 62 percent. Th Blues have 60 percent of all healt insurance policy-holders in Michigan, and are a multi-million dolla business.

8) The uniqueness of the proposals that BCBSM announced such as Physician Reimbursement Policy, including TLE, Vision and Hearing Care Plans;

9) The UAW package negotiated in one contract bargaining ses

---

continued on page 353

Down with pain
Step up to reliable relief

for mild to moderate pain

Wygesic® Ⓒ IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene…all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain

CONTRAINDICATION. Hypersensitivity to propoxyphene or to acetaminophen

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol tranquilizers sedative-hypnotics or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts as well as misuse of tranquilizers, alcohol or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks e g driving a car or operating machinery Patients should be cautioned accordingly

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore propoxyphene should not be used in pregnant women unless in the judgement of the physician, the potential benefits outweigh the possible hazards

USAGE IN CHILDREN Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group

PRECAUTIONS: Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness sedation nausea and vomiting These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down Other adverse reactions include constipation abdominal pain, skin rashes light-headedness headache weakness euphoria dysphoria and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported

DRUG INTERACTIONS: Propoxyphene in combination with alcohol tranquilizers, sedative-hypnotics and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma pupillary constriction, and circulatory collapse In addition to these characteristics which are reversed by narcotic antagonists such as naloxone there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported and apnea cardiac arrest, and death have occurred

Symptoms of massive overdosage with acetaminophen may include nausea vomiting anorexia and abdominal pain beginning shortly after ingestion and lasting for 12 to 24 hours However early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms the patient may feel less ill, however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity jaundice coagulation defects hypoglycemia, encephalopathy coma and death may follow Renal failure due to tubular necrosis and myocardiopathy, have also been reported

Ingestion of 10 grams or more of acetaminoohen may produce hepatotoxicity A 13-gram dose has reportedly been fatal

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists naloxone nalorphine and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered preferably I V , simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions

Oxygen IV fluids vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine which may cause anorexia nausea vomiting and drowsiness Appropriate literature should be consulted for further information (JAMA 237 2406-2407 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

Copyright © 1981, Wyeth Laboratories.
All rights reserved

Wyeth Laboratories
Philadelphia, PA 19101

PAIN AND TENSION...
Double fault for
weekend warriors
ACE THE ACHE
with

Equagesic®Ⓘⓥ

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

*****INDICATIONS**: Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use, i e more than four months has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons e g alcoholics, former addicts and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination

USAGE IN PREGNANCY AND LACTATION An increesed risk of congenital malformations associeted with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential mey be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times thet of meternal plasma When use of meprobamate is contemplated in breast-feeding petients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma shock vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken sleep ensues rapidly and blood pressure pulse and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g caffeine Metrazol or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses, peripheral edema and fever have also been reported

More severe cases, observed only very rarely may also have other allergic responses, including fever, fainting spells angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura agranulocytosis and hemolytic anemia In nearly every instance reported other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

Copyright © 1981, Wyeth Laboratories
All rights reserved

*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101
TM

sion in one state such as the participation/non-participation differential in Michigan, then applies to all UAW members across the country, testified Mr. Glasser.

"With this kind of economic power, is it any wonder why BCBSM is subservient to the UAW attitudes? Is it any wonder that BCBSM sits up and takes notice when the UAW expresses a keen interest in the number of formally participating physicians and continually keeps track of these numbers? Finally, is it any wonder why BCBSM would do almost anything to keep the account, including violating its enabling act to keep the UAW satisfied?"

"The UAW controls millions of individual citizens in the State of Michigan and will do everything in its power to see that the health care field is operated in the manner UAW deems appropriate," continued MSMS legal counsel. "The UAW is in effect a large buying group, the likes of which does not exist in any traditional industry or business.

"It is not hard to empathize with Michigan physicians. Can you imagine operating in an environment with an acrimonious behemoth whose specialty is draconian mandates?"

As for Medicaid

As the FTC also was investigating MSMS work with the Michigan Medicaid program, the Society's counsel stated that:

1) All MSMS activities in relation to Michigan Medicaid were for the purpose of strengthening the program;

2) MSMS, in fact, contributed to making the Medicaid program the best in the country;

3) Additionally, Michigan's legislature statutorily funds the Medicaid program and during the budgetary processes, MSMS's advice and input traditionally has been sought.

However, in answer to complaint counsel's question's, MSMS attorneys elaborated:

4) In 1975, during a dispute concerning a reduction in Medicaid's budget, MSMS made a policy statement that is could no longer urge its members to participate in the program. Rather, it left to each individual physician the decision of whether or not he/she wished to participate;

5) Later, when the dispute was resolved, MSMS amended its policy from neutrality on Medicaid participation to actively encouraging its members to participate in the program;

6) The Society's activities in relation to that budget disagreement were legitimate and legally permissible under the Noerr-Pennington Doctrine. It was conclusively established, during testimony, they said, that MSMS's neutrality resolution had no effect or impact on the Medicaid program.

To the question as to why MSMS requested powers of attorney concerning participation in Medicaid, MSMS lawyers said that evidence has established that there was no anticompetitive purpose behind the request. The person who originated the idea, Doctor Siegel, did not even think the powers of attorney were effective, he said, and the powers of attorney were never used by a MSMS representative in any way.

The MSMS position on the entire case brought by the FTC was put most succinctly and strongly in an introduction to the trial brief filed by MSMS legal counsel on behalf of MSMS.

"From the inception of this proceeding," MSMS legal counsel said, "MSMS has maintained that its actions were motivated by and should be viewed in, the context of economic, social and political considerations.

"A review of traditional antitrust concepts and the underlying policies for their creation illustrates that they were never contemplated to be applied, and, in fact, cannot be directly applied to the present factual setting.

"The complex subject area of the purchase and delivery of health care is unique. Unlike the traditional industries and businesses that the antitrust law were designed to regulate, health care delivery is and has been the subject of a multitude of debate concerning social ramifications and its abnormal economic dynamics.

"Obviously, the preservation of health affects everyone, and consequently everyone has joined the debate. Politicians are no exception. The entire health care delivery system, as well as portions thereof, has been the subject of proposed legislation on the state and federal level.

"Regrettably, via this action, the FTC's counsel have joined the fracas through an undesirable means. FTC counsel have stated the action was filed because of "naked and egregious and protracted" illegal acts. They proclaim that the action is nothing but a simple legal case. They claim the facts fit squarely within the existing body of antitrust law and they are merely the champions of competitive purity in Michigan.

"Try as hard as they might, this disguise could not be maintained forever.

Removal of the greasepaint

"Removal of the greasepaint began when, for the first time, FTC lawyers were required to make at least some type of definitive statement of the case in their trial brief. They used catch phrases such as 'free market system' and 'restraining competition' without meaningful explanation. They made conclusory assertions that MSMS interfered with this 'free market system' by 'restraining competition' without explaining how the purchase and delivery of health care in Michigan was a 'free market system' as traditionally defined, to begin with.

"Unwittingly, FTC lawyers began to prove, by their admissions, the differences between the traditional 'free market system' and the system involved in the present case. FTC witnesses admit that, at least for the purpose of establishing price, Blue Cross and Blue Shield of Michigan represents 60 percent of the health care consumers in Michigan. They admit, and in fact support the validity of, BCBSM's and behemoth third parties' (UAW and automobile manufacturers) acts of placing certain groups of suppliers (medical doctors) at a 'competitive disadvantage' to other similar suppliers.

"They admit, and in fact support the validity of, BCBSM and these behemoth third parties intentionally and artificially shifting the consumer public's 'demand' from one group of suppliers to another. They trumpet BCBSM's and these third parties' right to take any action they deem desirable.

"At the same time, the FTC lawyers denounce MSMS's First Amendment right to comment upon and object to these actions. They have shown the immense power and dominance of BCBSM and these third parties in the Michigan health care market. Amazingly, it is clear from their statements that the FTC lawyers believe that any acts to increase this power and dominance are legitimate. According to the FTC trial brief, BCBSM may do anything to increase its competitive advantage over other third-party carrier competitors including the artificial 'shifting of demand' of the consumer public and the anticompetitive act of placing some suppliers at a 'competitive disadvantage.'

"The FTC's trial brief reflects their social and political views of how the purchase and delivery of health care in Michigan should work, as opposed to the legality of the same. This fact is further buttressed by their trail presentation. One of the two primary substantive witnesses actually called to testify was Melvin A. Glasser of the UAW. On direct examination, FTC legal counsel did not elicit testimony on the operative facts, but rather had Mr. Glasser testify on his 'views' of how the health care delivery system *should* operate. He was far from shy in enunciating his socialistic views of the right of the UAW to intercede into and dictate the operation of the health care system. Mr. Glasser saw no contradition in his views, by his adamant statements that no one, but no one, is allowed to intercede or interject themselves into the UAW/automobile company relationship. As revealed on cross examination, Mr. Glasser could not provide factual support for his views. Mr. Glasser's testimony alone establishes the uniqueness of the Michigan health care delivery system.

"Your Honor's function is to adjudicate," MSMS attorneys addressed the judge. "The FTC seeks to have you adopt their social and political views under the guise of a legal action. Indeed, the FTC is attempting to disrupt the Michigan health care delivery system in a manner no one wants, to wit: elimination of meaningful physician input and domination of the Michigan health care system by a single third-party payer.

"It is nothing more, or less, than an attempt to have you legislate."

Here is what FTC judge's ruling would force MSMS to do:

IT IS . . . ORDERED that MSMS shall cease and desist from:

A. Entering into or attempting to enter into any agreement or understanding, either express or implied with any MSMS members to affect or attempt to affect the amount, manner of calculating, or terms of reimbursement, including, but not limited to, any agreement or understanding that:

1. any MSMS members will cancel or refuse to enter into, participation agreements;
2. any MSMS members will refuse to complete claim forms used by any third-party payer;
3. MSMS can act on behalf of any members through proxy, power of attorney, or otherwise, to cancel or refuse to enter into any participation agreement; or
4. any MSMS members will sign or enter participation agreements only on terms acceptable to MSMS or to any other MSMS member.

B. Advocating, suggesting, urging, advising, inducing, recommending that any MSMS members engage in any action to affect or attempt to affect the amount, manner of calculating, or terms of reimbursement, including, but not limited to, advocating, suggesting, urging, advising, inducing or recommending that any MSMS members:

1. cancel, or refuse to enter into, a participation agreement with any third-party payer;
2. refuse to complete claim forms used by any third-party payer;
3. agree to permit MSMS to act on behalf of any MSMS members through proxy, power of attorney, or otherwise, to cancel, or refuse to enter into, any participation agreement; or
4. sign or enter participation agreements only on terms acceptable to MSMS or to any other MSMS member.

C. Entering into or attempting to enter into any agreement or understanding, either express or implied, with any third-party payer concerning the amount, manner of calculating, or terms of reimbursement, or the terms or conditions of any participation agreement.

D. Acting or purporting to act as an agent for or representative of any MSMS members concerning their position with respect to the amount, manner of calculating, or terms of reimbursement, or concerning their decision to accept or reject the terms or conditions of any participation agreement.

E. Making any express or implied threat of acts by any MSMS members, or engaging in any other acts, with the purpose or effect of coercing, compelling or inducing any third-party payer to accept a position taken by MSMS or any MSMS members concerning the amount, manner of calculating, or terms of reimbursement, or the terms or conditions of any participation agreement.

IT IS FURTHER ORDERED that this Order shall not be construed to prevent MSMS from:

A. Participating in professional peer review of fees charged by individual physicians in individual cases.

B. Engaging in *bona fide* exercise of rights permitted under the First Amendment to the United States Constitution to petition any federal or state government executive agency or legislative body concerning legislation, rules or procedures, or to participate in any federal or state administrative or judicial proceeding.

C. Responding to a request for information or opinion by any third-party payer.

IT IS FURTHER ORDERED THAT MSMS:

A. Mail a copy of this decision and Order to each of its component societies, each of its specialty sections, and each of its members within thirty days following service of this Order.

B. Publish this Order on the first pages of an issue of *Michigan Medicine* published no later than 60 days after the date the Order is served, and on the first pages of the first *Medigram* published after the Order is served. The Order shall be published in the same type size normally used for articles which are published in *Michigan Medicine* and in the *Medigram*.

C. For a period of ten years, provide each new MSMS member with a copy of this decision and Order at the time the member is accepted into membership.

D. Require, as a condition of affiliation with MSMS, that any component society or specialty section agree by action taken by its governing body to be bound by the provisions of Parts I-III of this Order.

IT IS FURTHER ORDERED that MSMS shall file a written report with the Commission within ninety days of the date of service of this Order, and annually on the anniversary date of the original report for each of the five years thereafter, and at such other times as the Commission may by written notice to MSMS require, setting forth in detail the manner and form in which it has been complied with this Order.

IT IS FURTHER ORDERED that MSMS shall notify the Commission at least thirty days prior to any proposed change to itself, such as dissolution, assignment, or sale resulting in the emergence of a successor corporation or association, or any other change which may affect compliance with this Order.

Thomas F. Howder
Administrative Law Judge

June 19, 1981

Acute pain is no laughing matter.

The first prescription for the first days of acute pain

Empirin® c̄ Codeine #3

Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). C-III

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin c̄ Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin c̄ Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin c̄ Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths No 2 — 15 mg, No 3 — 30 mg, and No 4 — 60 mg (Warning — may be habit-forming.) C-III

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression When such combined therapy is contemplated, the dose of one or both agents should be reduced

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No 2 and No. 3 is one or two tablets every four hours as required The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Michigan part of pilot study on physician suicides

By Douglas A. Sargent, MD, Grosse Pointe Farms

Why physicians kill themselves and just how often they do it are questions that have puzzled our profession for years.

Until recently, however, pioneers calling for research to answer these questions have heard only the cynical echo, "physician, heal thyself." But the pressure of their questioning has finally paid off.

Late this spring, the AMA and the American Psychiatric Association announced what promises to be the first in-depth study of physician suicide. Michigan will be a part of the initial pilot study.

Financed by the AMA and conducted by experienced volunteer psychiatrists with the support of AMA staff, the study will explore the background and psychosocial characteristics of the suicidal physician in order to learn how to prevent these tragedies which yearly remove valuable colleagues from our profession.

Doctor Sargent is chairman, CSA Physician Suicide Panel, AMA; and member, MSMS Program to Assist Impaired Physicians.

At the urging of the medical student section of the AMA, the study has been broadened to include physician mortality from all causes, as well as deaths among medical students and residents-in-training.

The pilot study of possible and probable suicides occurring in 1981-82 will be conducted by means of in-depth interviews patterned after the "psychological autopsy." In addition, a 10 percent sample of deaths from all causes will be studied in the States of Arizona, California, Pennsylvania, Michigan and Oregon. Recently, MSMS agreed to participate in the study.

The states chosen for study comprise the 20 percent sample of the US physician population required by the AMA's Council on Scientific Affairs for inclusion in the pilot study. But these states were chosen mainly because each has a well-established medical society program for impaired physicians to provide organized assistance to the study, and because each has supplied a member to the APA's Committee on Impaired Physicians.

Under the leadership of Robert E. Jones, MD, its chairman, this APA committee is recruiting and selecting volunteer psychiatrists from the membership of the APA district branches, indoctrinating them in the procedures devised to safeguard the confidentiality, accuracy and thoroughness of the interviews, and supervising the conduct of the study in their respective states.

The data emerging from the interviews will be collected and processed by the AMA under conditions which guarantee privacy. Only approved researchers will have access to the data, from which all identifiers will have been removed to conceal the identity of both the deceased physicians and their relatives.

The psychiatrists conducting the interviews will be introduced to the deceased physicians' survivors by an associate, often a member of that state's medical society auxiliary. This personal contact is expected to enhance both the privacy and the benevolent purpose of the interview, which is likely to be somewhat emotionally stressful under the best of circumstances. Emotional support will be provided by auxiliary members whenever it appears to be needed.

Rogers Smith, MD, (University of Michigan, Medicine, 1945) Chairman of the AMA's Council on Scientific Affairs, appointed a panel of acknowledged experts in this field to supervise the pilot study. The panel includes Ralph Crawshaw, MD, a psychiatrist from Oregon; Donald Kieth, MD, a family practitioner from Oregon, Pat Tokarz, MD, a family practitioner from Virginia and Edward Seidel, a 4th year medical student from the University of Texas at Galveston. I have the honor to have been appointed chairman of the panel. Since I am a member of the APA Committee, I will also lead the study in Michigan.

The results of the pilot study will be analyzed and the scope of the study expanded if experience indicates that a wider study is likely to prove valuable. One possible outcome will be to establish a registry of physician deaths to be maintained by the AMA for research purposes. Another will be information with which to build more sophisticated programs for the prevention of suicide among physicians.

AMA believes heroin use will increase; issues MD guide

Given the high potency and relatively low price of current heroin supplies, many authorities believe that heroin use will increase, the American Medical Association declares.

The practice of smoking high-potency heroin is bringing heroin use to an affluent population that previously may have only experimented with cocaine inhalation.

This is one of many findings in the American Medical Association's new book for physicians: *Drug Abuse: A Guide for the Primary Care Physician.*

The book is written for physicians to assist them in treating drug abusers among their patients. It deals with causes, incidence, diagnosis and treatment. Medical and psychological implications of drug abuse are aired, along with methods for confronting and counseling drug abusers and their families. Pointers are given on prescribing practices that will curb abuse of regular prescription drugs.

Drug Abuse: A Guide for the Primary Care Physician is available from: Order Department OP-323, American Medical Association, P.O. Box 821, Monroe, WI 53566. Single copies are $15, plus $2 for handling.

There's always room for improvement... in your business communications. So call this toll-free number

1-800-482-2900

and ask about the "Business Improvements" brochure.

Michigan Bell
Affordable Business Improvements From Michigan Bell

Nobody's perfect. And the very first step toward improving your business communications could be a toll-free call to 1-800-482-2900 right now! Just ask about the brochure "Affordable Business Improvements from Michigan Bell," which is yours at no obligation.

Improve your equipment!

This informative brochure suggests dozens of ways you can improve your business communications techniques in a wide variety of ways; for example, through up-to-date equipment such as Touch-a-matic® Telephones, Dialog™ Intercom Systems, Speakerphones, Com Key® key telephone Systems and Horizon® Communications System, the new computerized self-programmable system . . . to name just a few.

Improve your services!

There are services available that can put an end to missed business calls—services that let your calls follow you when you leave your office, and sales services that show you how to improve sales and collections, and streamline your marketing techniques.

Improve your out-of-town business!

The brochure tells you ways you can "branch out" without leaving town, through a telephone service called Remote Call Forwarding. Foreign Exchange Service gives you local access to any area of the United States. 800 Service is still another way to make it easier for customers to reach you in seconds.

Improve your data transmission system!

The Dataspeed® 40 Terminal is one of the most advanced terminals offered anywhere! And if you want a fast, economical way to talk to your computer, you'll want to know more about Teleprinter 43. And that barely scratches the surface of the Michigan Bell data developments that could readily improve your business.

To get this fact-filled brochure at no obligation call the toll-free number above, or mail the coupon.

MICHIGAN BELL BUSINESS COMMUNICATIONS CENTER
Program Headquarters
101 Union Street
Plymouth, Michigan 48170

MM

Please send, without obligation to me, your brochure "Affordable Business Improvements from Michigan Bell."

Name Title

Company ( ) Area Code Business Phone No.

Street City State Zip

Michigan Bell

1981 MSMS Scientific Meeting offers courses reflecting the times

Doctor Cox

It's time to begin planning again for the MSMS Annual Scientific Meeting.

The big, three-day 1981 event is scheduled November 17-18-19 at the Hyatt Regency Dearborn. This year, nearly 60 half-day courses are planned by Chairman Frank Cox, MD, Detroit, and his MSMS Annual Scientific Meeting Task Force.

Once again, a total of 18 Category I credit hours may be earned by physicians attending the meeting. Costs again will be minimal in keeping with the MSMS policy of charging the lowest possible price for CME offerings to members. Fees are the same as they were in 1980: $5 per credit hour for MSMS members, $10 per credit hour for non-members, and $5 per course for residents. That makes the Annual Scientific Meeting one of the best CME buys in the state.

New features

New features of this year's program include several all-day courses planned jointly by two or more specialties, for a comprehensive look at a disease entity or treatment course.

Another major change is the separation of the Advanced Cardiac Life Support course from the Annual Scientific Meeting program. The ACLS course will be taught two weeks after the Scientific Meeting, with registration priority given to the participants in the Basic Cardiac Life Support course during the Annual Scientific Meeting. The ACLS course again will be sponsored and presented by the Michigan Chapter, American College of Emergency Physicians and will be staged at Lansing Community College on Dec. 4-5-6.

MSMS will repeat popular features of the 1980 program, including courses on treatment of chronic back, head and abdominal pain; sessions on hypertension, diabetes, stroke, breast cancer and dermatology for the non-dermatologist.

New courses are scheduled on:

"Occupational medicine for all physicians."
"Pulmonary Rehabilitation."
"Preventing Patient Injury."
"The Poisoned Patient."
"Gynecologic Surgery."
"Vertigo."
"Sleep Disorders."
"Arm Pain and Dysfunction."
"Stroke and the Eye."
"Bypass Surgery and Angiography."

Still other courses reflect the times:

"Drugs in the Elderly."
"Physician and Patient Teamwork."
"Prevention of Highway Injury."
"Genetics for the Practicing Physician."
"Aging — Should you Treat It?"
"Athletic Injuries to School Children and Adolescents."
"Treatment of Depression."
"Hospice — A Challenge to Physicians."
"Medical Ethics — Communication and Truth in the Doctor-Patient Relationship."
"Nuclear Medicine and the Practicing Physician."

Courses run from 8:30 a.m. to noon, and from 1:30 p.m. to 5, with half-hour coffee breaks.

Each course awards three Category I credit hours and is presented by a specialty society, MSMS section, or a department of one of the state's three medical schools. Courses go through a rigorous accreditation process and must be approved by the MSMS Annual Scientific Meeting Task Force in order to award Category I credits.

"We are trying to provide a broad range of topics particularly useful for the practicing physician in the various primary care areas," says Doctor Cox. "We also will provide courses targeted at specialty groups.

Audience participation

"We are encouraging audience participation as much as possible. We are planning actual case presentations, discussion by participants as well as faculty, and round table workshop sessions."

Doctor Cox, who is director of the Office of Continuing Medical Education at Henry Ford Hospital, comments that the Annual Scientific Meeting faculty widely represents the medical schools and major medical institutions of the state.

"We really have a good program underway," he says enthusiastically. "I'm very pleased."

The 1981 Annual Scientific Meeting facility again is the Hyatt Regency Dearborn, with its 12-story atrium, wing containing pool and meeting rooms, wide variety of restaurants, one of the few remaining Detroit-area nightclubs, "people-mover" automatic bus connections with the Fairlane Shopping Center, and proximity to Greenfield Village and Henry Ford Museum.

MSMS again will arrange luncheons for course participants and late afternoon free beer busts.

A large exhibit hall featuring booths by MSMS, affiliated organizations and 75 commercial exhibitors will be open each day and serve as the scene for the beer busts and MSMS-arranged luncheons.

A list of courses appeared in the second June issue of the MSMS *Medigram* newsletter. Registration forms and complete course information will follow in the September *Michigan Medicine*, and September and October *Medigrams*.

NEWS

By Bonnie L. Groff

New president of the Michigan Psychiatric Society is **Emanuel E. Tanay, MD**, Detroit. President-elect is **Joseph Fischoff, MD**, Detroit. . . . **John T. O'Connor, DO**, Lansing, is new president of the Michigan Association of Osteopathic Physicians and Surgeons, Inc. **William G. Anderson, DO**, Southfield, is president-elect. . . . **Margaret H. Zolen, MD**, Kalamazoo, is recipient of a "Community Achievement" award from her alma mater, Marshall University in Huntington, W. VA. . . . **Julian T. Hoff, MD**, Ann Arbor, is new professor of surgery and chief of neurosurgery at the University of Michigan. Doctor Hoff has been chief of neurosurgery at Moffitt Hospital, University of California, San Francisco, since 1977. . . . An article appeared in the April 24 *AM News* quoting **William N. Hubbard, Jr., MD**, Kalamazoo, on the process of drug approval. Doctor Hubbard, president of the Upjohn Company, feels major changes are needed to speed up the process. . . . New chairman of the Michigan Antitrust Law Section of the State Bar is **William Sankbeil**, Detroit, of Kerr, Russell and Weber. Mr. Sankbeil, former vice president of that section, steps into his new post in September. . . . **Ralph E. Kauffman, MD**, Detroit, is a new member of a panel of experts in the field of pediatrics to work with the United States Pharmacopeial Convention, Inc., in its drug-use information development programs. The panel aids in the publications of the USP Drug Information Division and provides advice to the USP Committee of Revision for the development of the official standards of strength, quality, purity, packaging and labeling. . . . A bronze mural commemorating the late **Ethelene Jones Crockett, MD**, was presented during the 77th annual meeting of the American Lung Association, held in Detroit's Cobo Hall. Doctor Crockett was the first woman to be president of the American Lung Association. . . . **Charles Oakes, MD**, is recipient of an MSMS Presidential Citation for his 55 years of medical service to his Harbor Beach community. In addition, he was honored at a dinner June 20, organized by the Harbor Beach Chamber of Commerce. Doctor Oakes was presented with a "Memory Book" of photographs, letters of best wishes and other memorabilia. . . . **Jack F. Sanders, MD**, Alma, received an honorary doctor of laws degree from Northwood Institute at spring commencement ceremonies. During the last 20 years, Doctor Sanders has done clinical research for pharmaceutical companies. His major effort has been with the Upjohn Company in diabetic research. . . . **Kenneth D. Hansen, MD**, Detroit, and **Rhoda M. Powsner, MD**, Ann Arbor, have been admitted to the bar. Doctor Hansen, who was admitted to the bar in a special ceremony before the U.S. Supreme Court in Washington, and Doctor Powsner are among just two dozen people in Michigan who hold degrees in both law and medicine. . . . **Richard M. Nowak, MD**, Detroit, is new secretary of the board of directors, Michigan Chapter, American College of Emergency Physicians. . . .

ST. CLAIR AMBULATORY CARE CORPORATION

Detroit, Michigan

IS ACCEPTING APPLICATIONS FOR THE FOLLOWING POSITIONS IN A NEW AMBULATORY CARE CENTER IN THE NORTHEAST DETROIT SUBURB OF ST. CLAIR SHORES.

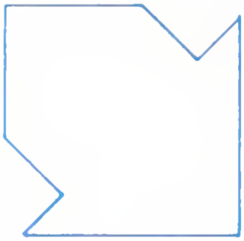
1. **INTERNIST; GENERAL MEDICINE WITH OR WITHOUT SUBSPECIALTY**
2. **OBSTETRICIAN-GYNECOLOGIST**
3. **PEDIATRICIAN; GENERAL PEDIATRICS**

THE NEW ST. CLAIR AMBULATORY CARE CENTER WILL BE A GROUP PRACTICE DEVOTED TO PRIMARY CARE, INITIALLY WITH TWO INTERNISTS, TWO OBSTETRICIANS, AND TWO PEDIATRICIANS WITH EXPANSION TO FOUR OF EACH AS INDICATED. COMPENSATION IS BASED PRIMARILY ON INCOME GENERATED WITH EXCELLENT FRINGE BENEFITS, AND A TWO YEAR INITIAL GUARANTEE.

APPLICANTS SHOULD BE BOARD CERTIFIED OR ELIGIBLE AND WILL NEED TO BE ACCEPTED FOR STAFF PRIVILEGES AT ST. JOHN HOSPITAL, AN AFFILIATE ALONG WITH ST. CLAIR AMBULATORY CARE CORPORATION, THE OXFORD INSTITUTE, AND THE ST. CLAIR RENAL CENTER, OF ST. CLAIR HEALTH SERVICES CORPORATION. APPLICANTS MAY APPLY IN CONFIDENCE TO:

**ROBERT E. BIRK, M.D., F.A.C.P.
DIRECTOR, MEDICAL AFFAIRS
ST. CLAIR AMBULATORY CARE CORPORATION
22151 MOROSS ROAD
DETROIT, MICHIGAN 48236
(313) 343-3875**

NEW MEMBERS



Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

James R. Addison, MD IM
Falls Clinic
Crystal Falls, 49920

Syed Arif Ahmed, MD FP/IM
P.O. Box 304
Marlette, 48453

David M. Alessi (Med. Student)
1400 Maple St.
Birmingham, 48008

Marcus G. Blass, MD GS
635 Morse St. A-6
Ionia, 48846

Peter M. Bozeman, MD AN
1045 Edinborough Dr.
Muskegon, 49441

Alfred J. Brown, II, MD U
3800 Woodward #824
Detroit, 48201

Jeffrey J. Colton, MD OTO
6777 W. Maple Rd.
West Bloomfield, 48033

Roberto D. Cordoba, MD TR
830 S. Jefferson Ave.
Saginaw, 48601

Barbara Ann Davies, MD PD
1675 Leahy #226
Muskegon, 49442

Bipin P. Desai, MD PD
8619 W. Grand Rapids, C
Brighton, 48116

William P. Drescher, MD P
535 N. Capitol Ave.
Lansing, 48933

Arthur A. Efros, MD IM
23100 Gardner
Oak Park, 48237

A. Joel Feldman, MD CDS/GS
32668 W. Haverford
Franklin, 48025

Steven D. Grant, MD IM
30335 W. 13 Mile Rd.
Farmington Hills, 48018

Rajesh C. Gulati, MD IM
975 Merriman Rd.
Westland, 48185

Norman R. Hutchinson, MD OPH
2799 W. Grand Blvd.
Detroit, 48202

Genowefa Jurek, MD PTH
Pontiac General Hospital/Path. Dept.
Pontiac, 48503

J. Jonas Kalnas, MD OM
Upjohn Company 5011-410
Kalamazoo, 49001

Kim F. Kezlarian, MD FP
1412 E. Wackerly
Midland, 48640

Timothy J. Kosinski, MD FP
2401 Wilmington Dr.
Midland, 48640

James E. Kursch, MD FP
1909 Crestwood Lane
Muskegon, 49441

John J. LaFerla, MD OBG
U of M Medical School, K-2026
Ann Arbor, 48109

James E. Leake, MD GS
671 Lovett, SE
Grand Rapids, 49506

Richard W. Lingenfelter, MD AN
7765 Bricklan Dr.
Canton, 48187

Mangaladevi Menon, MD OBG
U of M Medical Center
L-3208 Women's Hospital
Ann Arbor, 48109

Scott P. Monson, MD ORS
5991 Guilford
Detroit, 48224

Ramanathan Nagappan, MD IM/CD
1800 Nemoke Trail
Haslett, 48840

Chibuzo E. Nwachuku, MD OBG
18709 Meyers
Detroit, 48235

Wayne N. Pierantoni, MI PD
20136 Mack Ave.
Grosse Pte. Woods, 48236

Arnold M. Podolsky, MD A
24090 Ithaca
Oak Park, 48237

Michael J. Redmond, MD D
2120 Buckingham
Birmingham, 48008

Jerry H. Rosenberg, MD ORS
22301 Foster Winter Dr.
Southfield, 48075

Julia N. Sampat, MD IM
3140-A Rochester Rd.
Troy, 48084

Claire L. Scheele, MD GS
14965 Ashton
Detroit, 48223

Dinesh O. Shah, MD IM/CD
1201 W. Oakland #122
Lansing, 48914

Michael B. Shannon, MD NS
1431 Woodward Ave.
Bloomfield Hills, 48013

Theodore E. Spiro, MD PTH
Upjohn Company
Kalamazoo, 49001

Robert H. Sturman, MD NS
20755 Greenfield Rd.
Southfield, 48080

Neil Stuart Talon, MD P
7160 Suncrest Rd.
West Bloomfield, 48033

Ana Tamayo, MD OBG
2845 Woodcrest Way
Bloomfield Hills, 48013

Philomina C. Thomas, MD PD
22801 Gary Lane
St. Clair Shores, 48080

Nestor J. Truccone, MD PD/PDC
909 Woodward Ave. #101
Pontiac, 48053

P. G. Vijayakumaran, MD P
18585 Innsbrook Dr.
Northville, 48167

Steven G. Wildern, MD IM
1005 W. Green St.
Hastings, 49058

Roberta G. M. Zapp, MD IM
405 W. Greenlawn
Lansing, 48909

West loomfield's nost fashionable iddress. Most people can nly afford to dream about the estyle a select few can afford luxuriate in. Pine Lake Forest wnhouse condominiums are agnificently set upon the shores verlooking the crystal water of ine and Orchard Lakes.

Features like these are stand-rd to each unit: private elevator, athedral ceiling, Roman tub with cuzzi, electronic air cleaner and umidifier, two-car garage with wo additional parking spaces, elf-cleaning oven with built-in nicrowave top, sophisticated ecurity system. Even your own oat slip.

Pine Lake Forest represents ltra-luxury for people who have arned it.

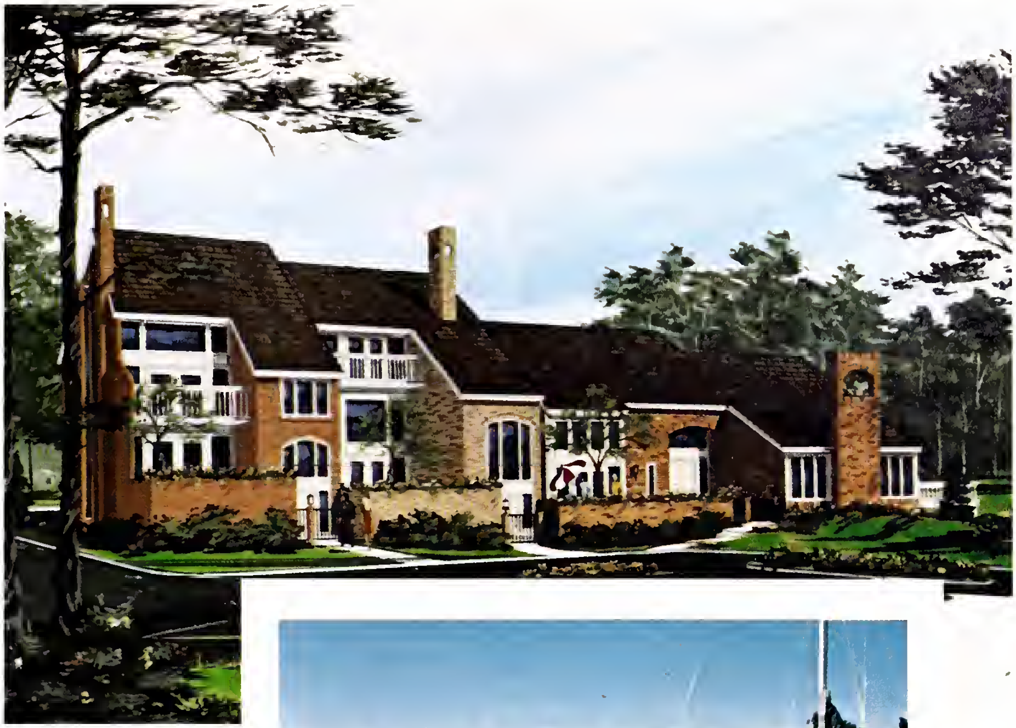
Dramatic. Intimate. Original. pulent. Mere adjectives unable capture these home's uintessence.

They are, simply, to become Vest Bloomfield's most fashion-ble address. If you are among he select, let us personally intro-luce you to them.

& 3 Bedroom Units
ppropriately priced
unrise Model from $390,000.
unset Model from $555,000.
rices subject to change without notice.

ales Office
300 Orchard Lake Road
lorth of Long Lake Road
13/681-8666 or 855-5522
pen 2 to 8 Daily

Subsidiary of Knoll Enterprises, Inc



Artist's conception

Lakeview in West Bloomfield

Pine Lake Forest
Townhouse condominiums

U.S. ARMY MEDICAL CAREER OPPORTUNITIES

We are looking for physicians who want to be physicians. We offer a practice that's practically perfect, where you work without worrying whether the patient can pay, without endless insurance forms, malpractice premiums, and cash flow worries, and where you prescribe, not the least care, not the defensive, but the best. If that is what you want, join the physicians who have joined the Army. Write us or call collect for the following information. We can offer:

Specialty Assignments
Residencies
Fellowships
Internships
Health Professions Scholarships
Employment Opportunities

Captain Gerard Indrisano
AMEDD Procurement Office
Federal Bldg.
200 E. Liberty St.
Ann Arbor, Mi 48107
(313) 668-2190

MEDICAL NEWSFRONTS

A new group of experimental drugs under study at The University of Michigan holds great promise for treating both cold sores and the presently incurable "herpes 2," now among the most common sexually transmitted diseases in the country.

The new drugs have successfully inhibited the growth of both types of herpes simplex viruses in the lab. Further, in animal tests for herpes some of the drugs have quickly cured the herpes sores without causing negative side effects.

Animal tests for herpes 2 have not yet been conducted.

A report on the new drugs (substituted 2 — acetylpyridine thiosemicarbazones) appears in the April issue of "Antimicrobial Agents and Chemotherapy," an official publication of the American Society of Microbiology. Co-authors are Charles Shipman, Jr., U-M associate professor of microbiology; technician Sandra H. Smith and biochemist John C. Drach, PhD, from Michigan, and Daniel L. Klayman, MD, of the Walter Reed Army Institute of Research in Washington, D.C.

Review of hospital charts of all 20 reported cases of Reye's Syndrome in Michigan this year has been completed.

The last two cases reported were excluded because histologic and laboratory data indicated another probable cause of those illnesses. The death reported in the last update memo was one of the cases excluded. Electron microscopy implicated prednisone hepatopathy as the cause of death. The other case was excluded because bacteria was found in the cerebrospinal fluid.

No new cases have occurred in Michigan for over two months. A total of 18 cases and no deaths have occurred since Sept. 1st, 1980. Sixteen cases were preceded by respiratory illnesses, 2 were preceded by chickenpox.

Three Michigan counties had two or more cases: Genesee, Kent and Monroe counties. No two cases attended the same school or lived in the same neighborhood. Cases were relatively evenly distributed with regard to age. Eleven cases were males; seven were females.

Fifteen of 18 cases were admitted at Stage 2 or lower. Only three cases were comatose on admission. Three cases did not exhibit any changes in mental status, i.e., were alert and oriented during the course of their illness. Twelve did not progress after admission. Five cases progressed one stage and none progressed two or more stages after admission. In one child treated with barbiturate induced coma, progression could not be assessed.

The National Cancer Institute (NCI) recommends that the active ingredient in marijuana, delta-9-tetrahydrocannabinol (THC), be made available to cancer patients who suffer from severe nausea and vomiting associated with chemotherapy, according to a report in the *Journal of the American Medical Association* (May 22).

In six out of seven studies involving 389 patients, THC was superior in treating cancer patients who were not helped by standard anti-nausea drugs, the NCI reports. In one study, THC was found equal to a major tranquilizer in effectiveness.

THC's action against nausea and vomiting was most pronounced when patients experienced a "high." A high can begin 20 to 60 minutes after the drug is taken and can last from one to five hours.

Although the studies used orally-administered THC, the NCI reports that inhaling the drug is a more reliable way of introducing it into the blood.

When we help establish your practice, your primary cares will be solved.

To establish a Primary Care practice, your first need is to solve your primary cares.

That's where we come in.

We can offer you a choice of over 60 well equipped acute care hospitals coast to coast. We can offer you selected financial assistance. We can offer you management consulting.

So whether you're interested in a solo, partnership, or group practice, contact NME today.

We'll help establish your practice.

And solve your primary cares.

For further information, contact:
Raymond C. Pruitt, Director, Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.
Call Toll-Free 800-421-7470
or collect (213) 479-5526.

NATIONAL MEDICAL ENTERPRISES, INC. NME
"The Total Health Care Company."
An Equal Opportunity Employer M/F

MDs must not prescribe controlled substances for dependent person's habit

The following is the text of a strong warning mailed May 29 to all licensed Michigan physicians. The Michigan Board of Medicine has asked *Michigan Medicine* to publish this information.

The Michigan Board of Medicine, has become increasingly concerned about the number of physicians who are prescribing controlled substances to individuals for purposes of maintaining that person's drug dependency.

The Michigan Board of Medicine wishes to advise physician licensees that the law speaks very specifically to this activity, and that physicians who are participating in this activity in an inappropriate manner are doing so at risk and peril to their professional licenses as well as to their controlled substance licenses.

Administrative Rule 63, being R 338.3163 of the Controlled Substances chapter of the Public Health Code, Act 368, PA 1978 as amended, states in paragraph (1)(a):

> "A prescriber licensed in accordance with federal and state law to conduct the drug treatment of a drug dependent person *in a program* may prescribe a controlled substance for the purpose of legitimate treatment of the drug dependent person."

This means that a physician may not prescribe controlled substances to a drug dependent person outside of a licensed drug treatment program to maintain that individual's drug dependency.

Furthermore, Administrative Rule 70, being R 338.3170 states in paragraph (2):

> "A prescriber may dispense or administer, or both, in the course of his or her professional practice a controlled substance listed in schedules 2, 3, 4, and 5 directly to the drug dependent person for the purpose of continuing his or her dependence *in a drug treatment and rehabilitation program*." (Emphasis added)

This means that a prescriber *may not* dispense or administer during the course of his or her professional practice controlled substances in the enumerated schedules *outside of a drug treatment program.*

Therefore, the Michigan Board of Medicine emphasizes very strongly that physicians should be very circumspect in their prescribing so as not to jeopardize their professional or controlled substance license for improper prescribing of controlled substances.

Physicians must be reminded of their economic responsibility

By Charles H. Wright, MD, Detroit

CO$T
EFFECTIVE
MEDICINE

Blue Pencil sketch

This article is excerpted from an address given by Doctor Wright to the Annual Convention and Scientific Assembly of the National Medical Association.

Despite the differences in opinion as to the physicians' responsibility for the inflationary rise in medical costs, it is clearly apparent that the responsibilty is significant. To that extent, a favorable influence can be exerted on cost containment, if a sincere effort is made to do so.

The unprecedented rise in the cost of delivering health care is causing economic and political repercussions throughout the nation. The physician is not only a part of the problem, he must be an active part of the solution. Dr. Thomas Nesbitt, ex-president of the American Medical Association, addressed this issue during his appearance before the Michigan State Medical Society in November 1978. He warned that organized medicine risks the loss of control of the profession unless we exercise more restraint against the rising costs of medical care.

Nesbitt observed, "The only way we're going to be able to practice effectively in a free environment is to be responsive to the concerns of government and the private sector." His suggestion was to create greater "cost consciousness" by physicians. He felt that such awareness on the part of physicians would encourage "treatment in the most economical way possible without unnecessary treatment and without extended hospital care."

You may recall that during the fall meeting of the Michigan State Medical Society, in 1978, a research team reported that the single most expensive item in hospital costs is the per diem cost of hospitalization. In an effort to implement the findings and recommendations of the research group, the Society gave each delegate a packet that included the following suggestions:

1. Learn hospital costs — Find opportunities to eliminate unnecessary procedures and substitute less expensive ones when possible.
2. Teach cost awareness — Take a hard look at diagnostic and therapeutic procedures and question their efficiency. House staff and students must be taught cost while they learn to treat patients.
3. Limit diagnostic tests.
4. Reduce hospitalization — Avoid the use of hospitals for convenience.
5. Exchange cost savings ideas with other physicians.

Health outlay

A government-financed study, conducted by Georgetown University, predicted that the health care outlay will climb from the present 8.5 percent of the Gross National Product to 12 percent by the year 2000. Their estimate is that by the turn of the century, more than one trillion dollars will be spent each year on medical care in the United States.

Blue Cross and Blue Shield Associations of America met in Chicago, in February 1979, and urged their member plans to stop paying for routine diagnostic tests required by hospitals. Walter McNerney, president of the Associations, urged that all diagnostic tests should be ordered by the physician of record for that patient.

Eisenberg and Rosoff doubt that the suggestion that physicians alone must order diagnostic tests would be a deterrent to waste of the health care dollar.

It is their contention that most diagnostic and therapeutic services are ordered by physicians who under fee-for-service conditions have little incentive to contain costs of medical care. Decrying their disappointment with Professional Standard Review Organizations, they recommended uniform but flexible definitions of medical necessity, reliable means for pre-determining the need for services, and effective penalties or incentives. They proposed a peer review system that included the sharing of financial risks among physicians, hospitals, insurors, and patients.

The findings and recommendations of Eisenberg and Rosoff have not gained widespread favor among many leaders in organized medicine. While some of them claim that voluntary measures have reversed the trend toward escalating medical costs, few agree that the doctor should be placed at financial risk for his contribution to the unnecessary expenditures.

Detroit situation

In an effort to evalute the Detroit situation, a look was taken at the experience with laparoscopy and diagnostic ultrasound performed in the Hutzel Hospital with the Detroit area Blue Shield Plan as payor.

We studied the use of laparoscopy as a primary procedure from 1974 onward; neither laparoscopy nor ultrasound was coded prior to 1974. While the number of laparoscopies has remained fairly constant, the number of ultrasound procedures has increased rather sharply.

Proponents of the liberal use of these diagnostic tools claim that they have reduced the amount of surgical procedures. Our figures on the five most common major gynecological operations do not support this assertion. Not only have the numbers of procedures increased, the fees for them have risen each year.

The Detroit office of Blue Shield

continued on page 366

No One Ever Sued Dr. Kildare For Malpractice

It's true. Back in 1962 when Dr. Kildare was one of television's most popular programs, millions of Americans would have been outraged. Richard Chamberlain and Raymond Massey almost always saved the patient and solved so many unusual diagnostic problems that they were our medical heroes.

And they did it without a CT scanner, an SMA 12, and all the other sophisticated technology which fills our hospitals today. Their patients loved them. Their viewers loved them. The drama flickering across America for 60 minutes each Thursday evening reassured us that our medical care was in good hands.

But this is 1981. The Age of Consumerism, Technology, and unfortunately. . . Litigation. US NEWS & WORLD REPORT stated there were 7 million lawsuits in 1978. That's one per every 30 Americans.

We still have our medical heroes. Quincy has been sued once for malpractice and he was an expert witness in another episode. Trapper John was also sued when he rendered emergency aid away from the hospital.

Times have changed. Society has changed. Medical skills, diagnostic expertise, and physicians' knowledge have increased significantly since the days of Dr. Kildare. Yet patients are suing physicians at a frequency which is alarming to the profession.

That's why in 1975, Michigan physicians chose to control their professional liability future by forming the Michigan Physicians Mutual Liability Company (MPMLC). A company owned, controlled, and totally supported by physicians.

MPMLC is your company. It is reacting to the 1980s by providing more coverages, reducing rates—the third reduction in the past four years, and responding to the needs of its insured physicians. Since issuing its first policy in May, 1976, MPMLC has become the second largest writer of medical professional liability coverage in Michigan. . . and the 25th largest in the country.

MPMLC is prepared for the Age of Litigation.

Your
Company

**Michigan Physicians
Mutual Liability Company**

P.O. Box 1471
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926 toll free

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

COST-EFFECTIVE/*continued*

provided the number of services and the charges for these same procedures for the same period of time. The annual payment to physicians and the percentage of change from one year to the next is computed. It must be remembered that this is but one of the costs incurred by these patients, most of whom were hospitalized.

Scanners cost

We learned the major rise is due to the proliferation of real-time scanners in doctors' offices. An alarming increase of service forms from these doctors to Blue Shield and Medicaid prompted an investigation. In some instances, doctors were conducting "fetal growth studies" at each obstetrical visit. Patients are being allowed to take the reports home to show their friends the image of the baby, enhancing the fame and fortune of the physician. Nonpregnant patients with abdominal complaints are being given routine abdominal scans with decreasing emphasis on the physical examination.

The Michigan Ob-Gyn Society, with gentle prodding from Blue Shield, met on the matter and agreed to suggest that not more than three scans should be done in pregnancy, unless there are extremely unusual circumstances.

If voluntary methods of cost containment are working, it is not apparent in this experience. Only the threat of federal control or bankruptcy forced some medical groups to mend their wasteful ways.

The medical staff of New York's Mount Sinai Medical Center, fearful that their institution would become a victim of the City's efforts to eliminate 5,000 beds in their area, heeded the warning of Dean and President Dr. Thomas C. Chalmers. "If we don't stop runaway costs ourselves, then the government will come in with a meat axe and destroy the quality of medical care we have achieved."

Doctor Chalmers' reference to the "quality of medical care we have achieved" may be a significant part of the problem of fiscal irresponsibility that is epidemic in most hospitals today. While all doctors must share some of the blame, recent medical graduates, who have been trained as medical technocrats, would often rather look at the laboratory reports than examine the patient. The patient is often not visualized in human terms. Thus, neither the physical inconvenience of repetitive and unnecessary tests nor the unarmed robbery inflicted on the pocketbook is of any real concern to the house officer. He has been trained to order and recheck every test remotely related to the patient's every complaint, with the hope that some clue to a diagnosis will be revealed, at whatever cost.

Confront burdens

The literature is replete with suggestions for the physician to mend his ways. Unfortunately, the implementation of such suggestions assumes awareness and concern on the part of the physician that are not always evident. Today's physician, unsure of his clinical judgement and threatened by the specter of litigation, is able to personally justify current medical practices. Rarely are the resultant economic burdens for their patients and third-party payors confronted by the physician.

Physicians must have constant reminders of their economic as well as their medical responsibility to their patients and to society. An effective reminder would place the physician at financial risk for any unnecessary waste of the medical-care dollar, due to his performance or his negligence of his responsibility.

A few rays of light are beginning to appear at the end of the tunnel. At least two medical schools have added courses on cost containment to their medical curriculums. While the area covered leaves much to be done, any step in the direction of raising the cost-consciousness level of prospective physicians is better than no step at all.

While the implementation of such programs will not be easy or without controversy, the results will be cost effective, will reduce the likelihood of external control, and will enhance the image of the physician as a responsible, concerned professional.

"Quality" United States & Canadian Decimals Since 1958

CARLTON
NUMISMATICS, INC.

- Professional Numismatic Counseling •
- Acquisition of Rare Coins •
- Portfolio Management •
- Investment Programs •

via
I.R.A., Keogh & Pension and Profit Sharing
Retirement Plans

To receive your complimentary copy
of our Current Price List and
Descriptive Brochures,
please write or telephone:

Bingham Center • Suite 1646
30700 Telegraph Road
Birmingham, Michigan 48010
313 / 646-8846

BUSINESS HOURS: Wednesday - Saturday 10:00 A.M. to 3:00 P.M. and by appointment.

Life Members A.N.A., C.N.A., M.S.N.S.: Associate Members C.A.N.D.

Beware look-alike, sound-alike drugs!

By Benjamin Teplitsky, RPh, Brooklyn, NY

As the number of prescription drugs grows, and as manufacturers keep coming up with new names, the possibility of mistaken identity is increased.

When look-alike names are written unclearly or sound-alike names are garbled over the telephone or into a dictation machine, the burden of avoiding misinterpretation may fall on others. It could be the nurse who has to dispense medications on the hospital ward or the pharmacist who fills the prescription. It is not infrequent for patients to receive a completely different drug because the doctor was confused by drug names.

In one instance, a physician's order for Amicar IV was erroneously filled with Amikin, and permanent renal damage ensued. In another, Estratabs were given in lieu of Ethatabs. The Ethatabs were to aid the circulation in the legs as a result of frostbite. Instead the patient developed enlarged breasts and allegedly became impotent. Novahistine given instead of Norlestrin resulted in a woman becoming pregnant because she thought she was taking birth control pills.

Other incidents with adverse results include: the interchange of levodopa and methyldopa; dilantin and deltalin; florinef and fiorinal; and pavulon and peptavlon.

Look-alike and sound-alike drug pairs may consist of:

Generic name — generic name
Acetohexamide - Acetazolamide
Digoxin - Digitoxin
Meprobamate - Meperidine
Brand name — brand name
Orinase - Ornade
Catapres - Catarase
Capastat - Cepastat
Brand name — generic name
Phenylzin - Phenelzine
Desoxyn - Digoxin
Chloromycetin - Chlorambucil

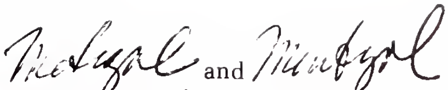
Drugs may also be classified as look-alikes, sound-alikes or both:

Look-alike drug names
Chlorpropamide - Chlorpromazine
Glutethimide - Guanethidine
Pavulon - Peptavlon
Sound-alike drug names
Iberol - Aberel
Ancobon - Oncovin
Fulvicin - Folbesyn
Sound-alike and look-alike drug names
Procarbazine - Decarbazine
Clotrimazole - Co-Trimazole
Paramethasone - Paramethadione

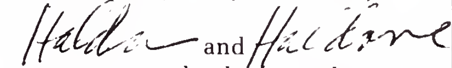
Many drug names look alike, and a hurried glance may fool the pharmacist, physician, or nurse.

Laxsil - Lasix
Ovral - Uval
Lidone - Dilone
Cytoxan - Cytosar
Herplex - Hiprex
Doxidan - Doriden
Cyclopar - Cyclapen
Cordran - Codeine

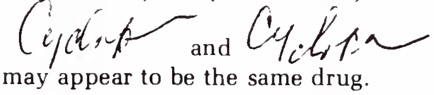
Reading the physician's handwriting, especially when scribbled in a hurry, may also present problems.



may appear to be the same drug.
(METRAZOL) (MINTEZOL)



may appear to be the same drug.
(HALODRIN) (HALDRONE)



may appear to be the same drug.
(CYCLAPEN) (CYCLOPAR)

It is urgent that the physician writes clearly, that the pharmacist double checks before he dispenses, calls the physician at the slightest doubt, and that the nurse does the same before she administers.

Remedial measures

- Prescription forms, like many other forms, should carry the line "PLEASE PRINT OR TYPE."
- Physicians should make it a habit to write the manufacturer's name alongside the drug.
- The pharmacist should receive a direct copy of the physician's order instead of a transcription from a nurse or a medication technician.
- Physicians should include the diagnosis on the prescription blank. This may help the pharmacist to relate the medication to the disease state.
- When dictating or giving names of medications over the phone, spelling out the names may prevent possible errors.
- The FDA should ensure that no products are placed on the market that resemble one another in name.

A tabulation of look-alike, sound-alike drug names is attached. Knowledge of such drugs can reduce the risk of error. Physicians are urged to exercise great care when writing or telephoning prescriptions.

Look-alike and sound-alike drugs

Aberel (acne)
Iberol (hematinic)

Acetohexamide (antidiabetic)
Acetazolamide (diuretic)

Achromycin (antibiotic)
Aureomycin (antibiotic)

Aerolone (bronchodilator)
Aralen (antimalarial)

Aerolone (bronchodilator)
Arlidin (vasodilator)

Mr. Teplitsky is a Brooklyn pharmacist. The MSMS Committee on Publications agreed to publish his article though it rarely accepts out-of-state authors, due to the importance of the subject.

Afrin (nasal decongestant)
Aspirin (analgesic)

Afrinol (nasal decongestant)
Afrin (nasal decongestant)

Agoral (laxative)
Argyrol (antiseptic)

Aldactone (diuretic)
Aldactazide (diuretic)

Aldoril (antihypertensive)
Aldomet (antihypertensive)

Ambenyl (cough preparation)
Ambodryl (antihistamine)

Ananase (enzyme)
Orinase (antidiabetic)

Anavar (anabolic)
Antepar (anthelmintic)

Ancobon (antifungal)
Oncovin (antineoplastic)

Anturane (gout)
Antuitrin (obesity)

Aralen (antimalarial)
Arlidin (vasodilator)

Asminyl (bronchial asthma)
Ismelin (hypertension)

Ativan (antianxiety)
Avitene (hemostatic)

Auralgan (ear drops)
Ophthalgan (diagnostic)

Benadryl (antihistamine)
Bentyl (antispasmodic)

Benzedrex (nasal decongestant)
Benzedrine (amphetamine)

Betapar (corticosteroid)
Betapen (antibiotic)

Bicillin (antibiotic)
V-Cillin (antibiotic)

Bontril (obesity)
Vontrol (antiemetic)

Brethine (bronchodilator)
Banthine (antispasmodic)

Brevital (general anesthetic)
Bretylol (antiarrhythmic)

Brondecon (bronchodilator)
Bronkotabs (bronchodilator)

Calamine (astringent)
Calomel (cathartic)

Centrum (vitamin)
Centrax (antianxiety)

Chloromycetin (antibiotic)
Chlor-Trimeton (antihistamine)

Codeine (narcotic)
Cordean (steroid)

Coenzyme-B (neuritis)
Cotazym-B (digestant)

Combid (GI disorders)
Combex (vitamin B complex)

Compazine (antiemetic)
Compocillin (antibiotic)

Cyclopar (antibiotic)
Cytosar (antineoplastic)

Daricon (antispasmodic)
Darvon (analgesic)

Darvon-N (analgesic)
Darvocet-N (analgesic)

Decadron (corticosteroid)
Percodan (analgesic)

Delalutin (antineoplastic)
Deladumone (androgen-estrogen)

Demerol (analgesic)
Dymelor (antidiabetic)

Demerol (analgesic)
Dicumarol (anticoagulant)

Desoxyn (antidepressant)
Digitoxin (antiarrhythmic)

Dilantin (anticonvulsant)
Deltalin (vitamin D)

Dilantin (anticonvulsant)
Delalutin (antineoplastic)

Dilantin (anticonvulsant)
Phelantin (anticonvulsant)

Dilaudid (analgesic)
Dilantin (anticonvulsant)

Disipal (parkinsonism)
Disophrol (cold remedy)

Dyclonine (anesthetic)
Dicyclomine (anticholinergic)

Ecotrin (analgesic)
Edecrin (diuretic)

Elavil (antidepressant)
Mellaril (tranquilizer)

Enarax (anticholinergic)
Marax (bronchodilator)

Endecon (antitussive)
Edecrin (diuretic)

Enduron (diuretic)
Eutron (hypertension)

Esimil (diuretic)
Estinyl (estrogen)

Ethionamide (antituberculosis)
Ethinamate (sedative)

Felsol (analgesic)
Feosol (hematinic)

Feosol (hematinic)
Feostat (hematinic)

Feostat (hematinic)
Feostim (hematinic)

Folbesyn (vitamin)
Fulvicin (antifungal)

Fostex (acne)
Phisohex (dermatologic)

Gelfoam (hemostatic)
Ger-O-Foam (anesthetic)

Glucoron (iron-mineral)
Glucagon (glucose elevating)

Halodrin (estrogen-androgen)
Haldrone (corticosteroid)

Halotestin (androgen def.)
Halothane (anesthetic)

Hiprex (antibacterial)
Herplex (antiviral)

Hycomine (antitussive)
Hycodan (analgesic)

Imuran (immunosuppressive)
Imferon (iron therapy)

Kemadrin (parkinsonism)
Coumadin (anticoagulant)

K-Lor (potassium replacement)
Klor (potassium replacement)

Lidaform (corticosteroid)
Vioform (antifungal)

Loridine (antibiotic)
Leritine (analgesic)

Mebaral (sedative)
Mellaril (tranquilizer)

Mesantoin (anticonvulsant)
Mestinon (myasthenia gravis)

Mellaril (tranquilizer)
Moderil (hypertension)

Metandren (androgen)
Metahydrin (diuretic)

Mephenytoin (anticonvulsant)
Mesantoin (anticonvulsant)

Metatensin (hypertension)
Mestinon (myasthenia gravis)

Metrazol (analeptic)
Mintezol (anthelmintic)

Nembutal (sedative)
Myambutol (tuberculostatic)

Nitrospan (angina pectoris)
Nitrostat (vasodilator)

Norlestrin (contraceptive)
Novahistine (decongestant)

Norlutin (amenorrhea)
Norlutate (amenorrhea)

Ornex (cold remedy)
Orexin (vitamin B_{12})

Orinase (antidiabetic)
Ornade (decongestant)

Otobiotic (otic prep.)
Otobione (otic prep.)

Persistin (analgesic)
Persantine (antianginal)

Pantopon (analgesic)
Protopam (antidote)

Pathocil (antibiotic)
Pitocin (oxytocic)

Pavabid (vasodilator)
Paveril (antispasmodic)

Pavulon (muscle relaxant)
Povan (anthelmintic)

Percodan (analgesic)
Percorten (mineralcorticoid)

Periactin (antihistamine)
Taractan (tranquilizer)

UPJOHN MOTRIN

For the pain of osteoarthritis
the proven power of

Motrin®
ibuprofen, Upjohn
600 mg Tablets
One tablet t.i.d.

Please see the following page for a brief summary of prescribing information.

Upjohn

981 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

Motrin® Tablets (ibuprofen, Upjohn)

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: **Blurred and/or diminished vision,** scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin;* use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.
Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.
Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.
Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)—Probable Causal Relationship
Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship**
Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown**
Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship" (PCR)* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

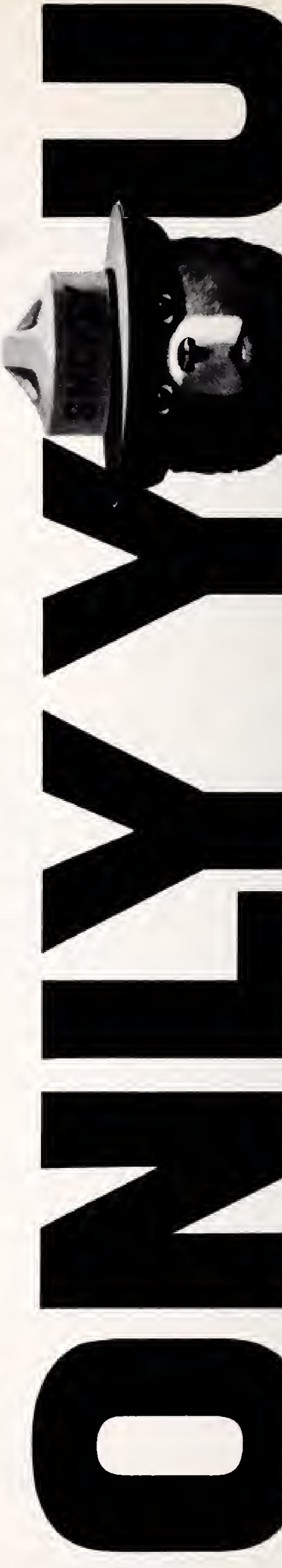
Caution: Federal law prohibits dispensing without prescription.

MED B-5-S

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

J-9042-4

July 1981



Ad Council A Public Service of This Magazine
& The Advertising Council

FOREST FIRE PREVENTION CAMPAIGN
MAGAZINE AD NO. FFP-1197-81
$2^1/_4$" x 10" [110 Screen] CP-2-81/CM-3-81

The University of Michigan Clinical Research Center: A state resource

By Irving H. Fox, MD, Ann Arbor

Drawing blood from young patient at the U-M Clinical Research Center.

On the fourth floor of University Hospital in Ann Arbor is a unique resource, the Clinical Research Center. This 18-bed unit, with associated laboratories, administrative offices and kitchen, is a setting in which clinical research studies are carried out with patient volunteers by University of Michigan faculty.

The Clinical Research Center is the only one of its kind in the state of Michigan. There are about 75 such centers located at leading hospitals and university hospitals around the country. These centers are supported by the General Clinical Research Centers Branch of the Division of Research Resources of the National Institutes of Health. In the current fiscal year, over $60 million will be spent on supporting Clinical Research Centers across this country.

Unique resource

Thus, the Clinical Research Center at the University Hospital is a unique, federally-funded resource available to physicians and patients throughout the state of Michigan.

Work at the U-M Clinical Research Center is based on premises that: 1) For physician-scientists to elucidate the complexities of human disease, humans only must be studied, as no substitute satisfies all research requirements. Animal models and other research concepts are useful in preliminary experiments. However, before any of these scientific advances may be applied generally to medical management, human trials must first be evaluated carefully. Furthermore, some diseases uniquely occur in humans and may not be modeled.

2) General wards within a hospital cannot cope with the complex care and treatment demanded by human research; a separate environment is needed. The pressing need for a discrete study unit, where ideal controlled conditions produce the most reliable results, led the faculty of The University of Michigan Medical School to apply for support to establish a Clinical Research Center at University Hospital. The Division of Research Resources at the NIH approved funding for the Clinical Research Center at The University of Michigan in Ann Arbor in 1961.

3) We believe the Clinical Research Center is an essential resource to both practicing physicians and patients in Michigan. Trained personnel are experts in carrying out clinical research studies. In addition, the Clinical Research Center grant program provides funds for the cost of the research and hospitalization in those instances where the research is not directly related to diagnosis and management of the patient's disease.

4) We also believe clinical research is critical for the continued discovery of new knowledge concerning the diagnosis, pathophysiology and management of disease. This type of work provides for continued increase in new information and assures improved medical care for our population in the future. Clinical research also gives patients who have diseases that are difficult to treat or are not curable by today's methods, an opportunity to participate in experiments designed to try to improve the understanding or management of their disease states.

5) Finally, the Clinical Research Center itself provides a training ground for introducing young physicians in training to the methods and approaches of the clinical researcher. The next generation of potential physician-scientists is thus exposed to the discipline, difficulties, ethical, and humanitarian approaches required by the active clinical researcher.

The principal investigator or chief administrator of the grant is John A. Gronvall, MD, Dean, U-M Medical School, who is responsible to the NIH for all research conducted in the center. With a special policy committee, he supervises the overall program. Irving Fox, MD, and William Ensminger, MD, program director and associate program director, respectively, are responsible for the day-to-day administration of the program. They are familiar with all protocols, follow the progress of each project, direct the core laboratory and diet kitchen, and teach concepts of clinical research to fellows, residents, interns, medical students and paramedical personnel.

While Doctors Fox and Ensminger are responsible for administrative duties of the GCRC, they are also two of more than 100 clinical investigators using the research facilities last year. They are advised by an operating committee formed of rotating medical school faculty. These committee members are themselves experienced medical scientists and are familiar with the center's research. They supervise the overall operation, approve projects and set patient admission policies.

Doctor Fox is program director of the Clinical Research Center.

U-M CENTER*/continued*

Research projects

Individual research projects are directed by U-M faculty members from many departments who typically are trained physician-scientists with considerable experience in human studies. They are assisted by the Clinical Research Center personnel and trainees including fellows, house officers and medical students.

Well over 95 individual research studies involving adults or children are currently active in the Clinical Research Center.

The research includes innovative approaches to managing the cancer patient, including the trial of new drugs, regional cancer chemotherapy with direct perfusion of brain tumors via the carotid arteries or the management of hepatic metastasis by hepatic arterial chemotherapy.

Studies in cardiology evaluate not only the roles of diet and exercise on blood lipids and coronary artery disease, but also the recent innovative angioplasty procedure which allows for a non-operative management of right coronary artery proximal lesions.

The extensive endocrine program is developing new insights and approaches to managing patients with anorexia nervosa and other types of hypothalamic amenorrhea, diabetes, islet cell tumors, pheochromocytoma, Cushing's syndrome and inherited endocrine syndromes. Innovative approaches to radionuclide imaging of the adrenal medulla have recently been developed and tested in the Clinical Research Center. In pediatric endocrinology, children who do not grow normally or have delayed puberty are being evaluated and treated on successful experimental protocols.

An extensive research program in the understanding and managing of inborn errors of metabolism has been initiated. Sickle cell disease, Wilson's disease, Lesch-Nyhan syndrome, cystinosis are among the inborn errors being evaluated. Finally, there is an unique obesity program which uses a multidisciplinary approach to the management of the patient with morbid obesity. Many other types of research not described here are of great importance and are active in the Clinical Research Center.

Patients key

The most important people in the Clinical Research Center are the patients. They are research volunteers whose cooperation and dedication make clinical investigation possible. The only criteria for admission are a patient's suitability and willingness to participate in a research project. Both sick and healthy patients are necessary to study particular medical problems. Well persons serve as normal controls, the valuable point of reference from which researchers study specific diseases or treatments.

All patients sick or well voluntarily agree to take part in any research study. Before accepting a research volunteer into any study, the physician must explain the study fully, outlining potential risks and benefits. The patient then must give his or her informed consent by signing a form stating that the physician has explained fully the situation and the patient understands what was explained. For pediatric patients, the parent or legal guardian signs for the child.

The protection of human subjects is an integral part of every clinical research program. Experiments to be carried out in human subjects must undergo careful scrutiny for both scientific merit and benefit versus risk to the patient. To supervise these functions, the U-M Medical School maintains an institutional review board composed of both physicians and professionals from other non-medical areas. This group reviews all protocols and ensures that the human subject is informed of the risks versus the possible benefits of the research. Patient rights include the opportunity to refuse to be a human subject without any jeopardy to health care and to judge whether risks related to the research are worth the potential outcomes of the research.

In addition to this, the Operating Committee of the Clinical Research Center maintains its own review committee which scrutinizes the proposals for research studies in humans for both scientific merit and ethical and humanistic considerations. It is when the University faculty members fulfill the requirements of both human subject protection and scientific merit that the experiments may be started in human subjects.

If a person is admitted as a research volunteer, the cost of that admission or outpatient visit may be paid by the grant to the University of Michigan from the National Institutes of Health. If the study involves an accepted form of treatment, the patient or the insurance company representing that patient is responsible for the costs of the medical care. In this case, the NIH grant to U of M pays only for those tests and procedures performed for research purposes.

Patients are hospitalized or are outpatients on the Clinical Research Center in University Hospital. In addition to 12 funded beds and 6 additional beds, facilities on the Center include treatment rooms, outpatients area, patient lounge, nurses station, conference room, core laboratory and a diet kitchen.

To be studied, patients must fit into an approved protocol, but new protocols can be designed for patients with unique medical problems. Physicians who may want a patient studied in the Clinical Research Center can call Doctor Fox or Doctor Ensminger (313) 764-3240. Area physicians also are invited to inquire about new clinical information or suggest new areas of research.

The Clinical Research Center is a state resource designed to serve physicians and patients in Michigan. The discoveries made are ultimately destined to be passed on to patients, directly benefiting local physicians and their patients. As a resource for the people of Michigan, the Clinical Research Center is available to complement patient care in the state by the discovery of new medical knowledge to assist and improve the diagnosis and management of patients. Your support and involvement is welcome and important.

Put us to the test.

Send us a split specimen—at our expense—we'll prove our accuracy.

First, establish an account with us. It won't cost you anything. Then at your convenience, draw a specimen using accepted procedures. Divide it and submit it under two names. When you receive the results, and you're satisfied they're statistically parallel, call us. We'll credit your account. It's that simple.

What else can you expect?

Quick results. We have three strategically located labs to provide routine test results within 24 hours, tissue results within 48 hours. Plus STAT service on some procedures.

Pickup and mail service. In many areas, our trained couriers will pick up your specimens. Outside our wide service areas, we provide prepaid mailing containers.

Quick-scan highlighted reports. Our reports were designed by pathologists. Abnormals are highlighted, making them easy to spot.

Staff pathologists. Abnormals are reviewed daily by our full-time staff pathologists. Any significant abnormal is immediately retested at no charge and the confirmed results phoned to you. Of course, our pathologists are available for consultation at any time.

Serum retention program. To make it easier for both you and your patient, every serum specimen is frozen for one week after initial testing. If further testing is necessary, just call us.

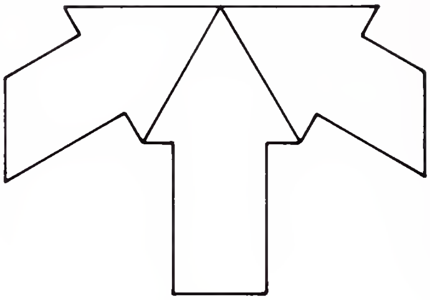
Accuracy assistance. We can assist you in training your personnel in laboratory procedures and proper specimen handling. Proper collection, handling and submission at your end further ensures accuracy at ours.

We're CBC and we've got a lot more to offer you. Our service is comprehensive, convenient, fast, and most important . . . accurate. Take the time to take our test. It may be one of the best things you ever do for your patients. And we *can* prove it.

To put us to the test call:
1-800-632-0706.

CBC CONTINENTAL
BIO-CLINICAL
LABORATORY SERVICE, INC.
Grand Rapids, Michigan • Toledo, Ohio
Mishawaka, Indiana

MEETINGS



MSMS, MSMS/A, AMA and medical assistants

July 16-19 — MSMS Council, Grand Traverse Hilton, contact: Warren Tryloff, MSMS headquarters.

July 18 — 1981 AMA Seminar for Improving English Pronunciation for Foreign Medical Graduates, AMA headquarters, contact: Department of Resident Services, AMA, 535 N. Dearborn, Chicago, 60610.

LOCUM TENENS

EMERGENCY MEDICAL POSITIONS

Emergency Consultants, Inc. has select opportunities in emergency medicine available on a locum tenens or full time basis. Positions in resort and recreational areas offer flexible scheduling, competitive hourly rates, and excellent benefits including malpractice insurance.

Emergency Consultants, Inc., a physician owned and operated corporation, currently services 60 hospitals in 12 states. Our organization accommodates professional and personal physician goals by providing a wide variety of locations with varying patient volume.

For further information contact: Emergency Consultants, Inc., Suite 115, 2240 South Airport Road, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

July 18-19 — Summer Seminar, State of Michigan Branch, American Association of Medical Assistants, Petoskey Holiday Inn, contact: Caroline Rich, MSMS headquarters.

July 25-26 — AMA Mass Media Communications Course, Marriott O'Hare Hotel, Chicago, contact: Speakers and Leadership Programs, AMA, 535 N. Dearborn St., Chicago, 60610.

Sept. 9 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Sept. 10-11 — AMA 41st Annual Congress on Occupational Health, Milwaukee, contact: Barbara S. Jansson, AMA, 535 N. Dearborn, Chicago, 60610, 312/751-6669.

Sept. 17-18 — American Medical Political Action Committee Political Education Conference, Washington, DC, contact: Diane Waltman, 202/857-1300 or write 1776 K St., N.W., Washington, DC, 20006.

Sept. 18-19 — AMA Hospital Medical Staff Leadership Seminar, Drake Hotel, Chicago, contact: Department of Hospitals and Health Facilities, AMA, 535 N. Dearborn St., Chicago, 60610.

Sept. 18-28 — MSMS/Intrav Italian Adventure, contact: Marcelyn Ireland, MSMS headquarters. 517/337-1351.

Oct. 21 — Fall leadership conference, MSMS Auxiliary, contact: Caroline Rich at MSMS headquarters.

Oct. 21 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 22 — Annual MSMS Public Affairs/Leadership Conference, Lansing Hilton Inn, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Nov. 3-4 — Diet & Exercise: Synergism in Health Maintenance, sponsored by the AMA, Walt Disney World Complex, Florida, contact: AMA Department of Foods and Nutrition, 535 N. Dearborn, Chicago, 60610.

Nov. 4 — MSMS 1981 Health Issues Conference — Identification and Management Approaches to Stress in the Contemporary Woman, Long's Convention Center, contact: Sherry Wellman, MSMS headquarters.

Nov. 7-8 — Fall Seminar, State of Michigan Branch, American Association of Medical Assistants, Holiday Inn, Battle Creek, contact: Caroline Rich, MSMS headquarters.

Nov. 17-19 — 1981 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings

July 29-30 — 24th Annual Congress of Delegates Meeting, Michigan Academy of Family Physicians, Holiday Inn, Traverse City, contact: Loretta Joyce, Executive Director, MAFP, 109 E. Oakland Ave., Lansing, 48906.

Aug. 3-5 — Michigan Academy of Family Physicians 35th Annual Scientific Assembly, Traverse City, contact: Loretta Joyce, Executive Director, MAFP, 109 E. Oakland Ave., Lansing, 48906.

Aug. 28-30 — Summer Meeting, Michigan Psychiatric Society, Holiday Inn, Traverse City, contact: Helen Schulte, MSMS headquarters.

Sept. 22-26 — American Medical Writers Association 41st Annual Conference, Prince Hotel, Toronto, contact: AMWA, 5272 River Rd., Suite 370, Bethesda, MD, 20016. 301/986-9119.

Oct. 1 — Michigan Psychiatric Society Council Meeting, Recess Club, Detroit, contact: Helen Schulte, MSMS headquarters.

Dec. 3 — Michigan Psychiatric Society Council Meeting, Recess Club, Detroit, contact: Helen Schulte, MSMS headquarters.

Naneva Hills

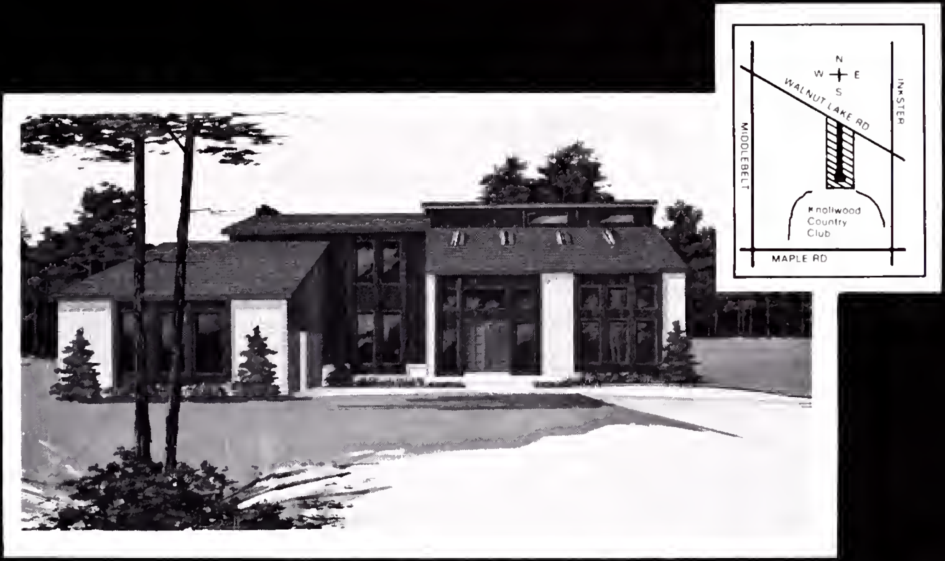
An artist creates only one original. A Calder. A Picasso. A Matisse. In sculpture, in paint, in ink, they work their individualized magic.

In beautiful West Bloomfield's Naneva Hills, Tambie Homes has designed and created an exclusive number of magnificent homes — each a Limited Edition.

Four dramatic homes on completely treed and landscaped lots are ready for Summer and Fall occupancy. There are also 3 lots remaining set against a beautiful ravine.

All the conveniences a discriminating buyer would expect are included: studio ceilings, ultra-modern kitchen (with full appliances like Jenn-Air and overstove microwave), Roman tubs, private library, skylites, large deck, wet bar, 2½ or 3-car garage, electronic air cleaner and much more. And there's still time to add your own personal decor touches.

Or bring us your own plans and we will custom build your house on yours or one of our lots. Determine your own price with our unique owner participation plan.



Limited Edition

Naneva Sales Center
313/851-3562

5801 Naneva Court
S. of Walnut Lake Road, between Inkster & Middlebelt

Presented by
Tambie Homes
A Subsidiary of Knoll Enterprises, Inc.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: July 19-21, Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** Benjamin Henig, MD, Keyport Clinic, 308 Michigan Ave., Grayling, 49738. **Approved for:** 12 hours of Category I Credit.

Date: July 19-21, Michigan Dermatological Society Annual Meeting. Location: Renaissance Center, Detroit. **Sponsor:** Michigan Dermatological Society. **For:** All interested dermatologists. **Contact:** Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067. **Approved for:** 6 hours of Category I Credit.

Date: July 26-29, 13th Annual Summer Conference. Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Opthalmological Society. **For:** All interested opthalmologists. **Contact:** Philip C. Hessburg, MD, 15401 E. Jefferson, Grosse Pte. Park, 48230. **Approved for:** 8 hours of Category I Credit.

Date: July 30-31, Coller Penberthy Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th & Madison Streets, Traverse City, 49684, 616/947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: July 31-Aug. 2, EKG Interpretation and Arrhythmia Management. Location: Shanty Creek Hilton Resort, Bellaire. **Sponsor:** International Medical Education Corporation. **For:** All interested physicians. **Cost:** $310. **Contact:** IMEC, 64 Inverness Drive East, Englewood, Colorado 80112. 1-800-525-8646. **Approved for:** 13 hours of Category I Credit.

Date: Aug. 19-21, Michigan Health Officers Association Annual Meeting. Location: Park Place, Traverse City. **Sponsor:** Michigan Health Officers Association. **For:** All interested physicians and health officers. **Contact:** William W. Moon, MD, Box 43, Harrietta, 49638. **Approved for:** 5 hours of Category I Credit.

Date: Aug. 28-31, Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical Center. **For:** All interested physicians. **Contact:** Janet Johnson, Office of CME, Towsley Center, U-M Medical Center, Ann Arbor, 48109, or call 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: August 29-30, Anatomy and Techniques of Regional Anesthesia. Location: Gordon H. Scott Hall, Wayne State University, Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All interested physicians. **Cost:** $175. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 DRHUHC, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 9-10, 1981 Western Michigan Trauma Symposium. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Greater Grand Rapids Area American Association of Critical Care Nurses, and the Committee on Trauma, Michigan Chapter of the American College of Surgeons. **For:** All interested physicians. **Cost:** $80. **Contact:** Beth DeVriendt, Butterworth Hospital, 100 Michigan, N.E., Grand Rapids, 49503. 616/774-1405. **Approved for:** 10 hours of Category I Credit.

Date: Sept. 14-18, Eighth Annual Family Practice Review. Location: Gordon H. Scott Hall, Wayne State University, Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All interested family physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 DRHUHC, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 40 hours of Category I Credit.

continued on page 378

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

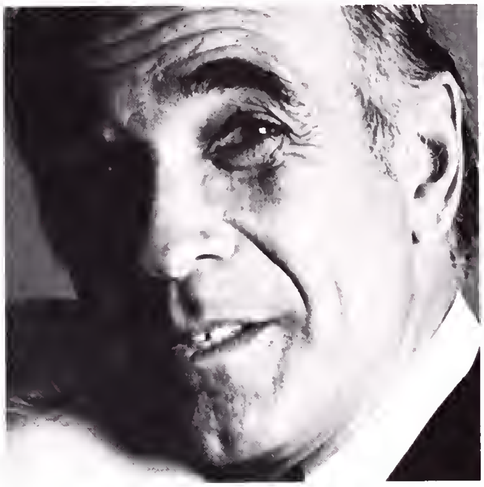
1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
143 Courtland Avenue
Rockford, Michigan 49341
(616) 866-9395

NOW THAT HIS
MEDICAL PROBLEM IS GONE...



SO IS HE.

When one of your patients fails to pay, it's tough to collect. But when he moves out of state, it's next to impossible. That's why your association approved I.C. System – a nationwide collection service. Whether a debtor has moved across town or across the country, let I.C. cover the extra miles for you. Mail this coupon today to learn how far...

The System
Works

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ______________________________

Address ______________________________

City ______________________________

State ____________________ Zip __________

Signature ______________________________

MSMS/A

By Barbara Grennan
Muskegon

The Medicare blues are a problem in our society today.

This is so for the elderly who must deal with forms they do not understand, with terminology that is unfamiliar and with a government that frightens them. It is so for physicians who must fight a system that denies them proper reimbursement for their services, that arbitrarily decides what is a reasonable fee and that fosters discontent among their patients. And it is so for medical assistants who must pacify patients who are dissatisfied with everyone, arbitrate dealings between Medicare and their employer and work to satisfy themselves that they have done their best.

The MSMS Auxiliary is embarking on a new project this year, a joint effort with the Michigan Association of Hospital Auxiliaries, to set up the mechanics for medical or hospital auxiliaries to give seminars for senior citizens regarding Medicare.

The cooperative effort involves the two sponsoring organizations plus Michigan Blue Cross Blue Shield, the American Association of Medical Assistants — State of Michigan Chapter, the Social Security Administrative office in Muskegon (where the pilot program will occur), the cooperation in that area of Senior Services of Muskegon and the Region 14 — Council on Aging. Also participating are the local medical and hospital auxiliaries. Planning for this has been underway for some time at the state level to insure approval and cooperation of MSMS and the approval of the boards of MSMS/A and MAHA.

The pilot program in what we hope will be a series of programs took place at the Muskegon YFCA on June 25. The cooperating agencies and groups formulated a plan that called for an introduction of the seminar followed by an explanation of the Medicare system by a Social Security representative, an explanation of co-payment and some of the other aspects associated with Blue Cross Blue Shield's participation in Medicare, then an address of specifics relative to the Medicare form by a representative from the medical assistants. There was a general question and answer session and following that, resource people provided by all three of these groups were available to aid those with specific problems.

Physicians throughout the state are encouraged to contact hospital or medical auxiliaries about the suitability of this program for their community.

This could be a valuable community service and hopefully it will be adapted by auxilians in the state in an attempt to better serve that segment of our population that must rely on the Medicare system for insurance coverage.

The title for these forums is "Understanding Health Care Coverage for Older Adults."

Mrs. Grennan is president of MSMS/A.

CATEGORY I/*continued*

Date: Sept. 16, Renal Disease for the Clinician. Location: Kalamazoo Hilton Inn. **Sponsor:** Michigan Nephrology Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Contact:** Charles L. Zeller, Jr., MD, Director/CME, SMAHEC, 252 E. Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, and the University of Michigan Medical Center. **For:** All interested physicians. **Contact:** Robert P. Means, Ph.D., Towsley Center for CME, University Medical Center, Ann Arbor, 48109, or phone 313/763-1423. **Approved for:** 16 hours of Category I Credit.

Date: September 30, Advances in Pediatric Hematology-Oncology: Clinical and Laboratory Review. Location: Room 2055, Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: October 3, **Immunochemical and Cellular Aspects of a B Cell Immunoproliferative Disorders. Location:** Room 2055 — Education & Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: October 3-4, 9th Annual Burns Clinic Medical Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinical Medical Center. **For:** All interested physicians. **Cost:** $120. **Contact:** J.R. Postle, MD, Chairman, Burns Clinic Medical Center, P.C., Petoskey, 49770, (616) 384-4500. **Approved for:** 12 hours of Category I Credit.

Date: Oct. 8-11, Regional Meeting, Michigan Chapter, American College of Physicians — Michigan Society of Internal Medicine. Location: Boyne Highlands, Harbor Springs. **Sponsor:** American College of Physicians and Michigan Society of Internal Medicine. **For:** All internists and primary care physicians. **Cost:** $30. **Contact:** Boy Frame, MD, FACP, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. **Approved for:** 21 hours of Category I Credit.

Date: Oct. 11-15, 1982, Abortion: Spontaneous and Induced. Location: Maui Surf Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1011. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-15, 1982, CDS: Contraceptive Delivery Systems. Location: Maui Marriott Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1101. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-16, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

Date: Oct. 15-17, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **For:** All interested physicians. **Cost:** $300. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, S.E., Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Oct. 26-30, Annual Review: Problems in Internal Medicine. Location: Room 2055, Education & Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Cost:** $200. $10 banquet fee, optional. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, (313) 876-1464. **Approved for:** 18 hours of Category I Credit.

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN

Healthy Competition
Makes A Healthier Market

Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.

Occurrence Coverage

Choice of limits— $100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

DEATHS

Carl B. Beeman, MD
Grand Rapids

Carl B. Beeman, MD, Grand Rapids, died April 22 at the age of 71. Doctor Beeman received his MD degree from Harvard Medical School in 1934. He was chief of staff at Blodgett Memorial Medical Center from 1957 to 1959. Doctor Beeman served as president of the Kent County Medical Society and the Michigan Heart Association. He was a member of the Michigan Society of Internal Medicine and a fellow of the American Board of Internal Medicine.

Edgar C. Long, MD
Sedona, AZ

Edgar C. Long, MD, Sedona, AZ, died April 6. He was 76. Doctor Long earned his MD degree from Wayne State University School of Medicine in 1935. During World War II, he was chief of surgical services at the Army General Hospital in Verdun, France. He served as chief of staff of Mercy Hospital and was past president of the Monroe County Medical Society. Doctor Long was a fellow in the American College of Surgeons and a diplomat of the American Board of Surgery.

William S. Martin, MD
Ludington

William S. Martin, MD, Ludington, died April 5 at the age of 74. Doctor Martin received his MD degree from the University of Michigan Medical School in 1931. He was the medical officer in charge of the United States Public Health Service station in the Ludington area. He was also the consulting physician for the Selective Service in the Ludington area. He maintained a private practice in Ludington until his retirement in 1980.

Virgil E. Stover, MD
Bradenton, FL

Virgil E. Stover, MD, Bradenton, FL, died April 16 at the age of 76. Doctor Stover received his MD degree from the University of Michigan Medical School in 1929. He was former vice president of the Kent County Medical Society and was affiliated with both St. Mary's and Blodgett Memorial hospitals.

Palmer E. Sutton, MD
Sunnyvale, CA

Palmer E. Sutton, MD, Sunnyvale, CA, died April 5. He was 84. Doctor Sutton earned his MD degree from Harvard Medical School in 1923. He was past president of the Oakland County Medical Society and was a member of the Michigan Society of Obstetricians and Gynecologists. Doctor Sutton was affiliated with William Beaumont, Women's and Herman Kiefer hospitals.

Administrative office and main laboratory

AMRC the full service laboratory

- Complete range of individual tests and diagnostic profiles
- Medical consultation services
- Comprehensive quality control program
- Fully accredited
- Complete billing service

Advance Medical &
Research Center, Inc.

1270 Doris Rd. • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

Self-insurance saves you money, but it needs the care of a money manager.

Many hospitals have found significant savings in self-insuring their malpractice coverage. In fact, in-hospital coverage of workmen's compensation and other employee benefit programs such as dental, health, disability and group life insurance has dramatically increased the use of self-insurance in medical institutions.

Proper administration of a self-insurance program, however, needs the services of an experienced investment manager, Detroit Bank & Trust.

We've served Michigan residents for over 130 years and rank as one of the largest trust institutions in the midwest. Our outstanding record as a manager of fixed income securities and our extensive experience in administering employee benefit programs have led many hospitals to choose us as their investment manager for self-insurance plans.

If you would like more information on how we can help you with your self-insurance or employee benefit programs, call or write Terry Keating, Vice President, at (313) 222-3898, Detroit Bank & Trust, Box 59, Detroit, Michigan 48232.

Self-insurance is not your most important job, but managing your money better is ours.

DETROIT
BANK
& TRUST

Member FDIC

Principal Trust Offices in
Detroit • Birmingham • Gaylord

Mr. Terrence E. Keating, Vice President
Detroit Bank & Trust
Post Office Box 59
Detroit, MI 48232

Please contact us in regard to administering our self-insurance program.

Name____________________ Title________________

Hospital____________________________________

Address____________________________________

City________________ State_________ Zip________

Telephone____________________

CON GAME/*continued from page 386*

meanwhile produced public outcry in the industrial northeast and midwest. In the late 1950s state insurance commissioners, who were responsible for approving Blue Cross rate increases, began to call into question the ability of the Blue Cross to represent the interest of its subscribers in holding down hospital costs. The voluntary hospitals and Blue Cross feared that the public might turn to the government to regulate hospital costs or to implement compulsory national health insurance if the Blue Cross failed financially or if the public lost further confidence in the system of private health insurance.

Private CON program

In Michigan, a state in which Blue Cross dominated the health insurance market, Blue Cross instituted what amounted to a private certificate-of-need program: it announced its intention to deny participating status to new hospitals that the voluntary regional planning agency would not certify as being "needed" (an action that effectively inhibited the construction of unapproved facilities) and it set standards for participating hospitals that allowed it, over time, to close down the smaller hospitals.

In New York, however, there are eight separate Blue Cross plans covering different geographical areas of the state. The leadership of the voluntary hospital sector and the Blue Cross there was more fragmented, and required the assistance of the state government in controlling hospital expansion. New York's certificate-of-need legislation, enacted in 1964, was the first of many hospital franchising laws. The purpose of the legislation was to put "teeth" into the decisions of the regional planning agencies that were the successors to the original Hill-Burton planning agencies.

Regional planning and CON were expected to accelerate the rise in hospital costs: that result was expressly anticipated in the *Trussel Report* on which the New York legislation was based, and was brought squarely to the attention of the Joint Legislative Committee on Health Insurance Plans by Milton Roemer, PhD, of the Cornell School of Hospital Administration. Doctor Roemer himself had postulated that "if a hospital bed exists it will be used," a proposition that had become known as "Roemer's Law." Doctor Roemer made it clear, however, that the major cause of spiraling hospital costs was the increasing sophistication of hospital-based care, not too many hospital beds. He explained that if CON regulation encouraged the trend toward more complex methods of treatment, it could be expected to increase the resources devoted to hospital care and therefore to increase total costs. He personally, however, supported CON legislation as a first step toward total government control of hospitals, which he thought was in the public interest.

The professionals' clear understanding that regional planning and CON would be cost-enhancing was never brought to public attention; since these measures were designed to provide an outlet for public frustration over hospital costs while avoiding actual cost control, their advocates were not anxious to provoke public debate. The fanfare surrounding passage of the New York CON law hailed it as a significant cost control measure. It was not until the mid-1970s that economists, investigating the effects of CON legislation, began to appreciate that costs in New York and other areas with CON controls had increased at a faster rate than they had in areas without such controls. CON seemed to have slowed the rate of increase in the number of hospital beds, but the beds being built were more capital- and labor-intensive and therefore much more costly. Small hospitals, which had lower *per diem* costs, were simultaneously decreasing in number.

By the time the actual consequences of CON had been ascertained, the federal government had imposed it on the states, under the mistaken impression that it would help to control hospital costs. The federal government, like the Blue Cross, needed to limit its total financial liability under Medicare and Medicaid; it also found community health planning an attractive idea. By 1979, all states but Louisiana had adopted some form of regional health planning and CON.

Hospital industry dominated

As we enter the 1980s, the hospital system envisioned by the proponents of regional planning and CON has largely been achieved. The hospital industry is dominated by the large, nonprofit, voluntary hospitals, which have used regional planning to create and maintain what amounts to a cost- and quality-enhancing cartel.

Experience with the system has made it apparent, however, that the medical, social, and economic consequences of concentrating care in large institutions are not desirable.

The challenge of the present era is to provide appropriate care in reasonably-accessible, noncentralized facilities in which the patient's needs, and not the institution's imperatives, determine the type of care provided.

In order to accomplish this it will be necessary to dismantle our system of health insurance, which has allowed the hospital industry to take its present shape.

Health professionals must also reconsider their commitment to the current planning system, which, although it has deep roots in the voluntary sector, also has the built-in, cost-enhancing, anticompetitive characteristics that have contributed to the high cost of medical care.

(References are available from authors.)

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

Many physicians will not have disability income protection to replace their loss of income...Most physicians will not have professional overhead coverage to pay their ongoing office expenses.

Will you be one of these physicians..."It won't happen to me."

Your MSMS group plans can provide this needed protection. For more information about rates and applications call toll free, 800-292-1966.

"we're here to help"

Stratton-Cheeseman & Associates, Inc.
1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823

*1979, The National Underwriter Company

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

WANTED: Board Certified or Eligible Neurologist to join solo incorporated Neurosurgeon in North Central Wisconsin. Send Resume to: 425 Pine Ridge Blvd., Suite 301, Wausau, WI 54401.

FAMILY PRACTITIONER — To locate in Sandusky, a small community with a 49-bed acute care hospital located near Lake Huron. Newly completed medical clinic building adjoining the hospital with office space available. For further information contact: Joseph W. Weiler, Administrator, McKenzie Memorial Hospital, 120 Delaware, Sandusky, MI 48471, (313) 648-3770.

GROUP HEALTH PLAN, a 24-year old, 140 physician, prepaid multi-specialty group with twelve clinics in the Minneapolis/Saint Paul area seeks board eligible or board certified associates in INTERNAL MEDICINE, ENDOCRINOLOGY, GASTROENTEROLOGY, OTOLARYNGOLOGY, OPHTHALMOLOGY, ORTHOPEDIC SURGERY, PEDIATRICS, and FAMILY PRACTICE. Positions available for 1981 and 1982. Send CV to: Paul Brat, MD, Group Health Plan, 2500 Como Avenue, Saint Paul, Minnesota 55108. An equal opportunity employer.

PLANT PHYSICIAN. Large industrial organization in Saginaw, Michigan, area has opening for medical doctor. Candidates should write to Box 18, Michigan State Medical Society, 120 W. Saginaw St., East Lansing, MI 48823.

DIRECTOR — FAMILY PRACTICE CENTER, FAMILY PRACTICE RESIDENCY PROGRAM: Holy Cross Hospital is looking for a physician to develop and direct a combined family practice service and education program in cooperation with the Department of Family Medicine, Wayne State University's School of Medicine. Candidates must be certified by the American Board of Family Practice with teaching and administrative experience in a family practice residency program. Salary will be competitive with private practice. A full spectrum of benefits will accompany this position, including a faculty appointment within the Department of Family Medicine, Wayne State University's School of Medicine. Please forward resume to: Bernardo M. Danan, MD, Chief of Medical Staff, Holy Cross Hospital, 4777 E. Outer Drive, Detroit, Michigan, 48234. An equal opportunity employer M/F.

POSITION NOW AVAILABLE in the Department of Internal Medicine for physician with subspecialty interest. 50 man multispecialty clinic in ideal location in Southern Wisconsin. Contact: R. E. Hassler, MD, The Monroe Clinic, Monroe, WI 53566, (608) 328-7000.

OPHTHALMOLOGIST WANTED to do office ophthalmology two or three days a week in well-equipped suburban office outside of Detroit. Excellent terms. Reply to Box 19, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

OPHTHALMOLOGIST FULL-TIME, outstanding opportunity to join busy practice in suburb of Detroit. Reply to Box 20, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

POSITION AVAILABLE. Family practice, educational program director. Applications are being accepted for this full time staff position with the Southwestern Michigan Area Health Education Center. This is a challenging opportunity in a clinically stimulating environment with an academic atmosphere. To be considered, an individual must be a fully trained family physician and certified (or imminently so) by the American Board of Family Practice. Duties and responsibilities will encompass many areas of activity, including undergraduate, graduate, and continuing medical education. A complete job description is available upon request. Compensation will include an appropriate stipend and fringe benefits package as well as a regular appointment to the faculty of the College of Human Medicine of Michigan State University. For details, contact: Robert M. Nicholson, MD, Executive Director, Southwestern Michigan Area Health Education Center, 252 E. Lovell Street, Kalamazoo, MI 49007, 616/383-7896.

NEED FULL TIME OR PART TIME PHYSICIAN OR P.A. in a busy general practice in semi-rural set-up close to Ann Arbor. Some industrial and insurance physicals. Very interesting and varied. Salary negotiable and commensurate with experience. Please call 313-697-9300 or send resume to Belleville Medical Clinic, 265 Main Street, Belleville, MI 48111.

PHYSICIAN NEEDED for Jackson Medical Center, Inc., a non-profit clinic providing medical care for patients in need, regardless of ability to pay. A permanent position with very attractive salary (approximately $50,000.00), 30-40 hour work week, no weekends, no nights, no hospital duty. Prefer family physician. Contact: E. Willoughby, MD, 569 Wildwood Ave., Jackson, MI 49201.

PHYSICIANS NEEDED IN ROGERS CITY AND POSEN, MICHIGAN. Excellent opportunity for physicians seeking a wide variety of financially rewarding professional experiences. Located near Lake Huron with excellent outdoor and family lifestyle. Attractive income guarantee in solo or group practice settings. If interested, call collect to: Evans Calas, Assistant Administrator, Rogers City Hospital, (517) 734-2151.

MEDICAL ONCOLOGY FELLOWSHIP. Currently available for 1 or 2 years at the Edward W. Sparrow Hospital, Lansing, Michigan. Emphasis on clinical training with research opportunities, including work in interferon trials. Prefer applicant who has completed 2 years of internal medical training. Send curriculum vitae to: Francis A. Breen, Jr., MD, Director of Medical Oncology, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, Michigan 48909. A Non-Discriminatory Affirmative Action Employer.

CALIFORNIA-DIRECTOR POSITIONS AVAILABLE. Emergency medicine physicians needed for rural Northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit-sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610. 415/832-6400.

PART-TIME PHYSICIAN needed to do routine physicals to assess donor suitability for plasmapheresis. Good position for older physician looking to slow down. Malpractice coverage provided. Contact Thomas Anderson at American Plasma Management, Kalamazoo, MI. Phone 616/381-0086.

Positions with The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Miscellaneous

HOWELL, MICHIGAN — Two suites available in attractively designed medical-dental building. Complex conveniently located within walking distance of hospital which serves fastest growing county in the state. Unlimited opportunity for hardworking family practitioner looking to establish large practice. For information, call (517) 546-7630.

BEAUTIFUL CHALET on Lake Superior 20 miles from Marquette on 10 acres of woods with 330′ lakeshore frontage. Cathedral living room with Franklin wood stove. Sleeps 8-10 comfortably with two bedrooms and large sleeping loft. Gas heat, lights, refrigerator and hot water. Fully insulated and furnished. No phone! Easy access 7-8 months of year. Only one other cottage in area. Dr. or Mrs. Robert White. (906) 225-1933. $53,500.

HOME-OFFICE FOR SALE — By owner, Mason, 12 miles south of Lansing. Growing area, good schools, commercial zoning. $72,000. 517-676-5081.

THE PERFECT RETREAT. Outstanding year round vacation home nestled in a secluded bay, in the midst of the North Woods of Michigan's upper peninsula. This custom designed home of rough sawn cedar has 12 ft. cathedral ceiling, 3 bedrooms, 2½ baths, 3 fireplaces, sauna and 50 ft. deck overlooking Portage Lakes' Torch Bay. The 100 ft. lakefront property includes adjacent guest house, with fireplace and deck, plus a 2 car garage. 15 minutes from Houghton-Hancock Jet Airport, downhill ski facilities and Lake Superior. Furnished if desired. Call (513) 871-7888 or 871-0632 or write R. Leonard Keppana, 3565 Bayard Dr., Cincinnati, OH 45208.

SNOWMASS/VAIL "MEP" SKI SEMINAR on Management Enrichment for the Health Professional. Ski Snowmass, Colorado the weeks of December 19, 1981 or March 20, 1982; or Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Trip expenses deductible for doctor and spouse. For information: M.E.P., An Education Corporation, 906 Cooper Avenue, Glenwood Springs, Colorado 81601; or 1-800-525-3402.

ON BEAUTIFUL AUSABLE RIVER (Main stream 195 ft. frontage, 3.6 acres). Prime trout fishing out your front door. Well insulated year around retreat. Wood stove plus brick fireplace. 4 bedrooms, two baths. Garage. 5 miles east of Grayling. $98,000 — Terms — #335 ask for Ruth. Century 21 River Country Grayling. (517) 348-5474 or (517) 348-9868.

HELICOPTER INVESTMENTS — We have available leases, sales, flight instruction, charter and a project consultant to assist you with your helicopter needs. Helicopters, Ltd., P.O. Box 667, 618 Silver Lake Rd., Linden, MI 48451. (313) 735-4121 or (313) 735-9018.

HISTORIC INDIAN VILLAGE LONG TERM LAND CONTRACT 11% — Authentic English Renaissance residence — walled garden, indoor fountain, imported gumwood paneling accented by sterling silver sconces and matching hardware, English paneled library, five granite fireplaces, excellent carriage house income (tax shelter), $125,000. Also other village properties available. Walker-Alkire Realty (313) 774-8200.

PHYSICIAN OFFICE FURNITURE for sale, in good condition, including three examining rooms, receptionist's desk and files, doctor's desk and chairs, waiting room and small lab available in Lansing area. Contact C. Dakak, MD (517) 332-7412.

HILTON HEAD ISLAND, SC. Ocean Villa, Captain's Cove in Palmetto Dunes Resort. Luxurious new villa, 150 yds from beach. Lagoon backyard, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, pool, fishing, canoeing, biking, etc. Weekly, monthly. Call or write, (313) 695-0356, 6236 Kings Crown Rd., Grand Blanc, MI 48439.

FOR SALE OR EXCHANGE — BY OWNER. Beautiful, almost-new summer home on approximately 12 acres on private lake with 400′ frontage. No motor boats allowed. Nearly 2 miles back in the woods, between Bitely and Baldwin, Michigan, adjacent to the 60,000-acre Manistee National Forest. 4 bedrooms, 3 baths, large rec room, large living room-dining room-kitchen combination. Laundry room with washer and dryer. Compactor, central vacuum system, public address and radio throughout. Air conditioning, gas furnace, deep well. 2 large fireplaces with heat-a-lators. Anderson Thermo-Pane windows. Wood paneling, carpeted, furnishings, including boats. All that and purple martins, too! Seller will finance at 12%. Price $149,500. Phone (616) 361-8439.

LUXURY CHALET FOR SALE, beautifully furnished, 5 large bedrooms, 3 full baths, in all-season northern Michigan resort. Golf, tennis, skiing, water sports, hunting, fishing, near excellent airport. Ideal for two-family or corporate ownership, too. Owner, (616) 587-9241 after May 25.

LAMINAGRAPHY SYSTEM — Approximately 15 years old. G.E. 300 ma, 125 KVP, Phillips table. Excellent condition, $9,800. Doctor S. G. Hastings, Box 335, Dexter, MI 48130. (313) 426-4632.

SANDRA W. COCHRAN, MEDICAL ILLUSTRATOR. Medical illustration available, from detailed realistic renderings to simple diagrams, graphic design and biophotography. For quality illustrations at the lowest cost, call (313) 652-2547, or write 1163 Ironwood Court, Apt. 104, Rochester, Michigan 48063.

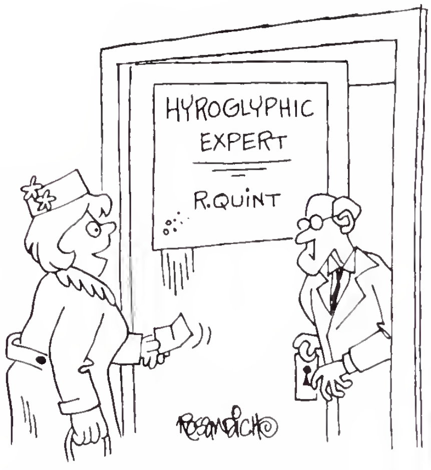
WE HAVE VARIOUS QUANTITIES OF MEDICAL EQUIPMENT available in excellent condition. We buy, sell, trade, move. New equipment also available. Call Doctor Medical Resale, (313) 569-4407, 9 a.m. to 9 p.m.

OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury, two & three bedroom units. Near Boyne ski hills. $92,000-$96,500. Furnished unit rentals available for vacation year round. A.K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

Thanks to our advertisers

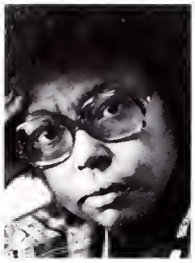
Advance Medical Research Center	380
Brown Pharmaceutical	349
Burroughs Wellcome	340, 355
Carlton Numismatics	366
CBC Lab	373
Detroit Bank and Trust	381
Emergency Consultants	374
Eli Lilly	347
IC Systems	377
Medical Protective	376
Michigan Bell Telephone	357
Michigan Physicians Mutual Liability Company	365
MSMS Annual Scientific Meeting	IFC
Naneva Hills	375
National Medical Enterprises	363
Physicians Insurance Company of Michigan	379
Pine Lake Forest	361
Roche Laboratories	338, 339, 340
St. Clair Ambulatory Care Corp.	359
Stratton Cheeseman	383
University Microfilms	340
Upjohn Co.	369, 370
U.S. Army	362
Wyeth Labs	351, 352



"Have you time for another prescription, professor?"

The CON game: High costs just what intended

By Sallyanne Payton, LLB, Rhoda M. Powsner, MD, Ann Arbor



Ms. Payton

Doctor Powsner

It is well-known that certificate of need regulation, which was widely adopted on the understanding that it would control hospital costs, has in fact contributed to the rapid rise in hospital costs.

Most of the strongly supported proposals for repeal of CON at both the state and federal levels have implicitly assumed that CON was a sincere effort at cost control that went awry.

A review of the origins of CON reveals, however, that the effects of regulation that are now deplored were anticipated and intended by the hospital and public health professionals who originally promoted CON legislation.

CON was the brainchild of the large, voluntary, nonprofit hospitals; the Blue Cross (their financial agent), and the United States Public Health Service; it was intended to legitimatize rising hospital costs and to protect and enhance the dominance of large nonprofit hospitals within the health care system by controlling hospital construction through regional planning.

The decisions of the planning agencies were implemented in states without CON by the Blue Cross, which denied participating status to unapproved new hospitals. In states with CON the state denied licensure to hospitals that built or expanded without approval.

Collective planning has long been practiced in the hospital industry, particularly in the industrial northeastern and midwestern states, dating in some instances to the turn of the century. After World War II the American Hospital Association, the United States Public Health Service, and the philanthropies most involved in medical affairs collaborated to obtain passage of the Hill-Burton Act, which was designed to bring hospitals to rural areas and to establish the large teaching and referral hospital as the center of medical care delivery. The Hill-Burton Act laid the foundation for a nationwide network of regional health planning agencies.

In the postwar suburban building boom, hospital construction had burgeoned; the resulting proliferation of suburban hospitals threatened the tidy regional structure preferred by the USPHS and, more critically, threatened the financial solvency of the Blue Cross. So long as Blue Cross granted participating hospital status to the new hospitals, it was obligated to reimburse them for their full costs of care, which meant that all hospitals, new and old, would be supported financially, whether or not they were fully used. The perverse effects of widespread health insurance and full-cost reimbursement to hospitals had become apparent. In addition, the new hospitals being built in the suburbs threatened the older, downtown institutions. In response, the AHA and the USPHS promoted regional planning (now also called "areawide planning") as a means of controlling suburban hospital growth.

Rising Blue Cross rates had

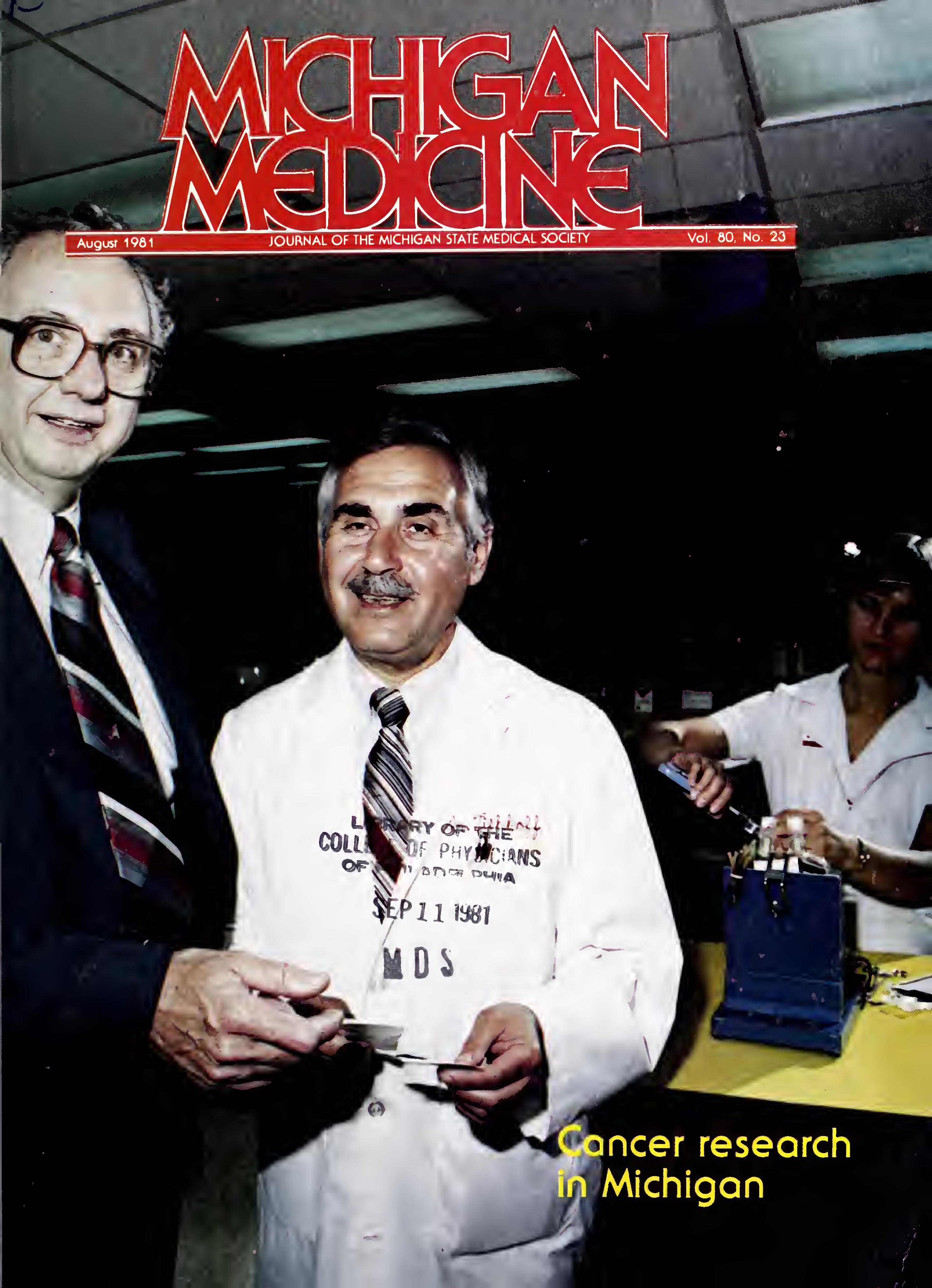
continued on page 382

Sallyanne Payton is an associate professor of law at the University of Michigan Law School, where she specializes in administrative law and regulation. She is a member of the Administrative Conference of the United States. Doctor Powsner is in the private practice of internal medicine and cardiology in Ann Arbor. She recently received a JD from the University of Michigan and was admitted to the Michigan Bar. Doctor Powsner is the MSMS representative on the Arbitration Advisory Committee to the Insurance Commissioner. She has served on the Area VII PSRO criteria committee, and is a consultant in legal medicine. She is a clinical instructor at the U-M.

The authors hold the copyright on this article. Requests for its further use should be directed to them. The ideas expressed in this article were first described in an article, "Regulation through the Looking Glass: Hospitals, Blue Cross, and Certificate of Need," 79 *Michigan Law Review*, 203, (1980).

MICHIGAN MEDICINE

August 1981 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 80, No. 23



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
SEP 11 1981
MDS

Cancer research in Michigan

"Any Way You Cut It"

You can hone your skills and knowledge by attending the 1981 MSMS Annual Scientific Meeting. The deeper you look into our CME courses, the more you'll like what you see. This meeting offers expert, up-to-date information for practicing Michigan physicians, at low cost, in an easy-access location. You can earn up to 18 hours of Category I CME credit and make your choices from 57 varied courses. Come to the Hyatt Regency Dearborn, November 17-18-19 and let MSMS help you put a fine edge on your scientific education.

1981
MSMS ANNUAL
SCIENTIFIC MEETING
November 17-18-19, 1981
Hyatt Regency Dearborn

A collaborative interferon program, under the direction of the Department of Medicine in MSU's College of Human Medicine, also involves the Michigan Department of Public Health and the Great Lakes Red Cross Blood Program. Our cover photo of the principals involved in this program relates to the special report in this month's issue on Michigan cancer research and developments. Pictured are: Kenneth Wilcox, MD, left, chief of the MDPH Bureau of Disease Control and Laboratory Services, and Garson H. Tishkoff, MD, MSU professor of medicine and scientific director of the American Red Cross Mid-Michigan Chapter. In the background is medical technologist Sue Nietupski. **(Photo by Richard Wesley)**

MICHIGAN MEDICINE
August 1981, Volume 80, Number 23

Special report

392 The news on cancer research in Michigan is heartening and encouraging. It fills the reader with pride in the quantity and quality of good programs, the dedication and teamwork of physicians and researchers and the truly exciting advances they are making. Reports from each of the medical schools appear in this issue, which should serve as a reference to physicians on what's happening in cancer research and treatment in our state; Scott N. Swisher, MD; Laurence H. Baker, MD, Anna Yee; and Albert F. LoBuglio, MD

Features

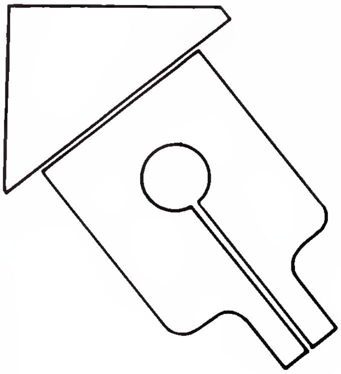
402 Interferon in Michigan; Jeffrey Rich
408 Michigan Board of Medicine disciplinary actions
410 Lansing arthroscopic clinic a 'consumer item' after first year; Kim White
414 Jackson's Doctor Neikamp marshals health care army to deliver high school physical exams
420 BCBSM organizes to establish HMO in every major Michigan city; Dwight Angell
424 BCBSM regional cost committees; Deborah Zannoth
428 Cost-effective medicine; Robert M. Nalbandian, MD
430 Enhancing caregiver-infant interactions; Samuel J. Meisels, EdD
435 Maternal Health Desk Reference Card No. 26: Herpes Simplex Viral Infections in Pregnancy
440 Annual Scientific Meeting courses meet stringent requirements
454 'Stress and the Contemporary Woman' theme of MSMS conference Nov. 4

Departments

388 Letters
407 New members
439 Medical newsfronts
444 Meetings
446 Category I courses
450 Deaths
452 Classified
453 Ad index

MD

LETTERS



Report on PAs

In response to the article "Update on Physician's Assistants," submitted by freelance writer, Dwight Angell (*Michigan Medicine*, May, 1981), I thought you might appreciate the following comments:

1. The Western Michigan University Physicians' Assistants Program has been in operation since 1972 and during the subsequent nine years has benefitted from a great deal of warmth and acceptance from the entire medical community, physicians, hospital staffs, nurses, other health professionals and consumers of health care.

It was, therefore, somewhat difficult for me to feel comfortable with Mr. Angell's choice of the term "bastard child" in describing PA acceptance in the State of Michigan. That feeling also does not correlate with the fact that 167 physicians and 58 clinical institutions are currently affiliated with the WMU PA Program. It does not correlate well with the current employment of more than 300 PAs in Michigan and 14,000 nationwide. Nor does it correlate well with the acceptance shown by more than 2,000,000 people in the State of Michigan served by physician/PA teams.

2. Statistics for graduates vary from program to program. Since the national statistics differ from those presented in the article it may be of interest to your readers to see the U.S. distribution:

- Fifty-five percent of PAs are in or immediately adjacent to Health Manpower Shortage Areas (medically undersupplied towns, townships, counties).
- Over one-third of graduates practice in rural settings (as defined by the AMA this means towns under 10,000) where 25 percent of the population resides.
- Fifty-three percent of PAs are in communities of less than 50,000 where 37 percent of the population resides.
- Approximately 83 percent of PAs assist in providing primary care services, of which a majority (44 percent) are working with family practice physicians.

3. The statement, "A PA can perform about 75-80 percent of what a family physician can do" is misleading and could be inflammatory. PAs are educated to perform acts, tasks and functions that are within the domain of primary care practice. That does not mean that on a linear scale they can deal with 75-80 percent of the types of problems with which physicians deal. Rather, I am sure Mr. Angell meant that PAs are educated to deal with the more routine items in medicine which, for some practices, numerically comprise a large portion of the patient encounters each day.

4. In regard to his comment that the Board of Medicine and the Board of Osteopathic Physicians and Surgeons have not promulgated rules, I hope that Mr. Angell did not intend to infer that these two boards have not pursued the matter of rules with

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
John R. Ylvisaker, MD, Pontiac

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $20.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. ©1981 Michigan State Medical Society.

vigor. My experiences indicate that the boards and the task force have indeed been diligent. I am aware of a number of meetings wherein both boards, the PA Task Force and many interested individuals have discussed rules which govern physicians who are approved to supervise PAs. The boards, the task force and the legislature are purposefully concerned to provide the best health care for the people of Michigan and the best administrative/licensing process for the practitioners involved. Perhaps Doctor Kallet (Medical Practice Board) said it best: "One must use the test of reasonable, customary usage." This may be the ultimate philosophy to adopt. By this, I mean to say that the best rules might simply require physicians to retain the responsibility for total supervision of the physician's assistant, and delegate such acts, tasks and functions as he/she feels are appropriate to the education and experiences of the PA. As a consumer, I feel most comfortable with that option of those available.

Congratulations to *Michigan Medicine* and MSMS for articles on physicians' assistants. An enlightened medical community as well as enlightened consumers will recognize that PAs are dependent practitioners who can be of great aid to physicians in Michigan and elsewhere, especially with our very rural and very urban areas. Since PAs extend physician capabilities to help people, they assist in providing quality health care to individuals not otherwise adequately served. And that, after all, is what the whole medical community is working toward.

For readers interested in the sources of information stated above, or information on productivity of PAs, quality of care by PAs, history of the profession, legislation, sample hospital guidelines, preceptor information or application information, please feel free to write to the program.

Norman P. Johnson, PhD
Program Director
Western Michigan University
Physicians' Assistants Program
Kalamazoo

More on PAs

The article on the physician assistant in the May, 1981, issue was extremely well done and provided some insight into the role of the physician assistant. Additionally, it pointed out the excellent licensing procedure required by Michigan, as well as the need to develop rules and regulations that will allow the physician assistant to function within the intent of the law.

The Michigan Academy of Physician Assistants supports the development of these rules. In the past, we have worked closely with the Task Force, the Board of Medicine and the Board of Osteopathic Physicians and Surgeons toward this goal, and will continue to do so in the future.

The Physician Assistant is a dependent practitioner functioning under the responsible supervision of the licensed physician. This role statement permeates the education and philosophy of the physician assistant. When a physician employs a physician assistant, it allows him/her to extend his/her capabilities and knowledge and ultimately, improve the health care and education of each patient. This becomes especially important for the busy physician in the medically underserved areas of Michigan.

As noted by the statistics, 59 percent of the physician assistants in Michigan practice in areas (rural, inner city) that are addressing the health care needs of the medically underserved. This has been and continues to be a major goal of the profession. The national statistics are very similar, with 48 percent of the 14,000 physician assistants working in population areas of less than 50,000 persons.

Again, may we commend you for your fine review of the physician assistant profession in Michigan.

Judith B. Willis, MA, PA-C
President, Michigan Academy of
Physician Assistants
Director, American Academy of
Physician Assistants
Lansing

Physicians' art

Many physicians throughout history have been involved in creative hobbies, such as painting, sculpturing, photography, and crafts. However, in the United States it was not until 1936 that they had an organization in which they could exhibit these creative ventures. At that time the American Physicians Art Association was organized by the late Frances H. Redewill, Sr., MD, a San Francisco urologist and a talented marine painter. He and some other physician artists had the first exhibition of APAA at the convention of the American Medical Association in San Francisco in 1936.

The majority of members of the APAA are active, artistic creators who exhibit their work in one or more of the following categories; oils and acrylics, water colors, sculpture, photography, arts and crafts, and/or graphics and miscellaneous.

This year the APAA Annual Art Exhibition and annual meeting will be held during the 75th annual Southern Medical Association meeting in New Orleans, Nov. 15-18. Membership in the Southern Medical Association, however, is not required.

Membership is open to all physicians. Those interested should write to Milton S. Good, MD, Treasurer, APAA, 610 Highlawn Ave., Elizabethtown, PA 17022.

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/Roche) (IV), please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® ⓘⓥ
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

ROCHE®
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

This publication is available in microform.

University Microfilms International

Please send additional information
Name
Institution
Street
City
State Zip

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London W1N 7RA
England

MEDICAL DIRECTOR

Rapidly expanding mental health center in need of a Medical Director who would be responsible for the administration of medical care and for the medical treatment of all patients of the Center. Specific duties will include organization and performance of the Quality Assurance Program, preventative and consultative services, medical records supervision, provision of medical evaluations, scheduling of psychiatric time for case staffing, and 24-hour psychiatric coverage. Excellent opportunity for a dynamic psychiatrist interested in community mental health and seeking a challenge. Applicants must be board certified or eligible in Psychiatry and licensed in the State of Indiana. Must have successfully completed a 3-year residency approved by the American Board of Psychiatry and Neurology. At least 2 years' experience in a related field and/or experience working with a multi-disciplinary staff is preferred. Send resume to:

Glenn A. Kuipers
Center Director
TRI-CITY COMMUNITY
MENTAL HEALTH CENTER
3901 Indianapolis Blvd.
East Chicago, IN 46312

An Equal Opportunity Employer

SPECIAL REPORT

Michigan's cancer research programs improving the outlook on many fronts

Michigan State University scientists figure largely in the collaborative interferon program mounted by the Department of Medicine in MSU's College of Human Medicine, the Michigan Department of Public Health and the Great Lakes Red Cross Blood Program. The program also involves clinical oncologists in Grand Rapids, Saginaw, Flint and Kalamazoo. Some of the principals (shown with medical technologist Sue Nietupski) include, from left, Kenneth Wilcox, MD, chief, MDPH Bureau of Disease Control and Laboratory Services; Garson H. Tishkoff, MD, MSU professor of medicine and scientific director of the American Red Cross Mid-Michigan Chapter, and John A. Penner, MD, professor of medicine and chief of hematology/oncology at MSU.

At MSU, research projects span college, disciplinary boundaries

By Scott N. Swisher, MD
East Lansing

Doctor Swisher is associate dean for research, Michigan State University College of Human Medicine.

Cancer-related research at Michigan State University not only spans boundaries of disciplines, but also those of MSU's three medical schools (College of Human Medicine, College of Osteopathic Medicine and College of Veterinary Medicine) and the College of Natural Science. More than 40 research projects with direct bearing on cancer are currently underway in the jointly administered basic science departments and in the clinical departments of the individual medical schools.

An overview of a number of representative projects is presented here. At MSU, as elsewhere, there also are many research efforts of basic biological nature which do not yet appear to be useful in understanding cancer, but which may yield crucial insights in the future.

In the clinical area, a program to

study the therapeutic effects of human leukocyte γ and α interferon has been mounted. This collaborative program, directed by Nickolay Dimitrov, MD, of the Department of Medicine in the College of Human Medicine (CHM), involves the production, standardization and testing of interferon produced by the Michigan Department of Public Health Laboratories, employing leukocytes produced by the Great Lakes Red Cross Blood program. Clinical oncologists in Grand Rapids, Saginaw, Flint, and Kalamazoo are participating in a jointly developed, rigidly controlled therapeutic trial of this material with oncologists from MSU. More than 80 patients will be involved in the trial.

Clinical research

Trials of a number of chemotherapy programs also are being carried out by the oncology group of the CHM Department of Medicine. As an example, MSU participated in the National Adjuvant Surgical Breast Protocol under the direction of L. G. Shurland, MD, who also holds an American Cancer Society professorship in clinical oncology. Investigations of methods of cancer education and cancer prevention are also underway, supported by grants from the National Cancer Institute.

A number of investigations of psychological and social factors which affect cancer patients and their ability to cope with the disease also are in progress.

The Immunology and Serology Laboratory of the Department of Medicine, directed by Robert Bull, DVM, has two programs in cancer research.

The first is a human histocompatibility laboratory. It provides the necessary laboratory techniques for the matching of bone marrow donors with patients that have defective marrows as a result of a variety of neoplastic diseases.

The second program is being done in collaboration with the Great Lakes Red Cross Blood program. The laboratory is typing 5,000 of the volunteer blood donors for the HLA system. This will allow the appropriate matching of platelet donors for patients with cancer who have a decreased platelet count and require significant numbers of platelet transfusions. This will support further research directed at making such transfusions more efficient and effective. The work is being carried out by Dr. Kenneth Schwartz, MD, of the Department of Medicine.

Barnett Rosenberg, PhD, of the Department of Biophysics (CNS) is continuing his research on the tumoricidal properties of a variety of metal coordination complexes. This work led Doctor Rosenberg and colleagues to the earlier and internationally publicized discovery of a group of platinum compounds which are now in widespread use clinically in the treatment of certain human cancers.

A number of investigations involve spontaneously developing malignant diseases of animals. A comparative study of breast cancer in dogs reflects a cooperative program between the Department of Medicine of CHM and CVM. Leland Velicer, DVM, PhD, (CVM), Department of Microbiology and Public Health, is studying the relationship between certain malignancies induced in chickens by viruses and their subsequent genetic expression in the neoplastic cells.

This work is being done in close collaboration with The Regional Poultry Research Laboratory, a unit of the US Department of Agriculture located in the MSU campus area. It is closely affiliated with Michigan State University, particularly the Agricultural Experiment Station, and the Departments of Biochemistry and Microbiology and Public Health. The laboratory has nine full-time scientists with a support group of about 40 persons. They conduct basic and applied research on viral induced neoplasms of chickens and turkeys, including Marek's disease, lymphoid leukosis and reticuloendotheliosis.

Basic research

The basic research of James Trosko, PhD, and Chia-Cheng Chang, PhD, of the Department of Pediatrics and Human Development (CHM) is based on the concept that both genetic factors and environmental agents interacting with each other determine the risk of cancer. There is evidence that most cancers are the result of two distinct processes, namely *initiation* and *promotion* during the development of the tumor. The research is aimed at delineating the molecular basis for both the initiation and promotion phases of carcinogenesis.

Cells derived from various mammalian and human sources are grown in tissue culture. Molecular, biochemical, genetic and genotoxic assays are performed on these cells to determine if various chemicals act as initiators (mutagens or agents which damage DNA) or as promoters (agents which block cell-cell communication). To study some of the genetic factors predisposing individuals to cancer, Doctors Trosko and Chang are using cells derived from young children who suffer from various genetic-cancer syndromes (i.e., xeroderma pigmentosum, Bloom's, Cockayne) to see if they are susceptible to initiators or promoters or both. Their laboratory was the first to demonstrate that human cells could repair genetic damage caused by environmental mutagents and was involved in the determination that xeroderma pigmentosum individuals who are predisposed to sunlight-induced skin cancer could not repair sunlight-induced DNA damage in the cells.

Clifford Welsch, MD, (CVM) of the Department of Anatomy is investigating the hormonal regulation of growth, differentiation and tumorigenesis of human breast tissues *in vivo*. Slices of normal human breast tissues are transplanted to, and maintained in, hormone treated athymic "nude" mice. Growth of the grafts are assessed by ^{3}H-thymidine radioautography and differentiation of the grafts are assessed by a-lactalbumin radio-immunoassay and histological analysis. By altering the endocrine system of the host mice, it is possible for the first time to define the *in vivo* hormonal environment required for growth and differentiation of human breast tissue. Doctor Welsch also is studying the mammary tumorigenic suppressive activities of retinoids (vitamin A analogues) in carcinogen-treated rats by concurrent hormone suppression and/or immune stimulation.

Evelyn Rivera, PhD, (CNS) of the Department of Zoology is studying the development of carcinogen-induced (dimethybenz(a)anthracene-induced) breast tumors in rats. The study is based on the concept of dual pathways in the development of mammary tumors; tumors may arise directly from transformed cells in mammary ducts or indirectly from transformed cells in benign hyperplastic nodules. A variety of environmental factors are being studied in attempts both to enhance or arrest the course of tumor progression from these tissues. She is also developing a culture system for *in vitro* transformation of mammary cells by carcinogen, and attempting to explain data which indicates that DMBA-induced mammary tumors are composed of heterogeneous cell populations.

John L. Wang, PhD, (COM) of the Department of Biochemistry is studying the density-dependent inhibition of growth in cultured fibroblasts.

Cells from neoplastic sources are often relatively insensitive to the normal growth regulatory program and cannot shift into the quiescent state. One of the fundamental problems in the study of growth control is, therefore, the nature and sites of action of agents that can shift cells from one state to the other.

DNA research

A number of systems have been established for the study of the stimulation of quiescent cells into DNA synthesis and the proliferative state and several endogenous growth stimulatory factors have been isolated and characterized. Less is known about endogenous growth inhibitory factors that may function to convert proliferative cells into the quiescent state, the principle focus of this research.

Doctor Wang has found that a medium conditioned by exposure to density-inhibited 3T3 mouse fibroblasts specifically inhibited DNA synthesis and cell proliferation in a sparse culture of growing 3T3 cells. Fractionation of this growth inhibitory activity has yielded two polypeptide chains that interact directly with plasma membrane receptors on target 3T3 cells. Further studies will identify the cellular sites of action and the biochemical mechanism of the isolated growth regulator fraction, and their differential effects on normal and neoplastic cells.

Harold C. Miller, PhD, (COM), Department of Microbiology and Public Health, is studying immunoregulation by shed tumor membrane complexes.

Cancerous cells of lymphoma and neuroblastoma types produce select glycolipid membrane components (gangliosides-Thy-1) which are capable of confusing the normal cells of the immune system that provide for daily protection against the microbial and neoplastic world. Normally the immune response provided by helpful and aggressive lymphocytes is regulated by Thy-1 gangliosides shed from antigen-activated lymphocytes that are derived from the thymus. Their effects last only long enough to protect B lymphocytes (bone marrow origin) from being overwhelmed with molecules that trigger development into antibody-secreting cells.

This system is studied to attempt ways of suppressing the cancer cell shedding of membrane molecules and hence, restoring normal immune fractions by the host. For this work, a laser-activated cell sorter is used to purify and characterize the protective lymphocytes and the metastatic cancerous cell populations. Modern cloning techniques and cell culture provide the additional research tools for this study.

The MSU College of Osteopathic Medicine in 1976 established the Carcinogenesis Laboratory to conduct a large transdisciplinary science research program directed to understanding the basic mechanisms responsible for human cancer. Although strong evidence suggests that environmental agents (chemicals) are responsible for the majority of human cancer, the biochemical mechanisms by which normal human cells are transformed into tumor-producing cells are not yet understood.

Laboratory goals

The goal of the Carcinogenesis Laboratory, under the joint direction of J. Justin McCormick, PhD, and Veronica M. Maher, PhD, is to gain insight into these processes so that strategies can be developed to interrupt this malignant transformation. A combination of approaches — biochemical, biological, genetic, and biophysical — are employed to test radiation and chemicals which cause cancer for their ability to induce mutations in normal human cells and in cells derived from persons with a genetic predisposition to cancer and/or defective DNA repair. These agents have been shown to damage the genetic material in the cell. If this DNA damage is not repaired in time it can cause cell death, mutations, and the transformation of normal cells into cancer cells.

Since most chemical carcinogens form a number of different kinds of damage to DNA which are not equivalent in their biological consequences, it is important to discern which of these are critical for the cytotoxic, mutagenic and/or carcinogenic process. To do so, the laboratory has developed techniques for exposing the human cells to radioactive carcinogens and measuring which DNA damage correlates with which biological effects.

The laboratory has recently succeeded in demonstrating in repair-proficient and repair-deficient human cells that DNA damage is directly correlated with the transformation process. To demonstrate that the transformed cells are malignant, they injected them into specifically-bred athymic mice which lack the immunological competence to reject foreign human tumor cells but do not allow non-malignant cells to grow. The researchers obtained tumors (fibrosarcomas) composed of human cells.

WSU's faculty and administration dedicated to help solve citizens' cancer problems

By Laurence H. Baker, MD
Anna Yee
Detroit

William Powers, MD, demonstrates the fluoroscopic simulator in the Detroit Medical Center's new $5 million Radiation Oncology Center. The machine allows the physician to simulate the radiation therapy and therefore determine the exact dosage levels and distribution of the powerful radiation beams required in the cancer treatment. Doctor Powers is professor and chairman of the Department of Radiation Oncology at Wayne State University School of Medicine, chief of radiation oncology at Harper-Grace Hospital and director of the Radiation Oncology Center.

The cancer program at Wayne State University is organized to foster excellent inter-departmental and interdisciplinary activities in cancer research and care. In excess of $5,000,000 annually is received by the faculty of the University in peer-review national grant programs.

Clinical activities occur within the ultra modern facilities of the Detroit Medical Center. Facilities housed within this center that are unique include: a protected environment unit and laboratories to support allogenic and autologous bone marrow transplantation; IBM cell separators and computer-assisted HLA matching laboratories to provide individualized blood component replacement therapy; a state-of-the-art 25,000 square foot radiation oncology center; a 10-bed palliative care unit for patients with advanced disease; and a Ronald McDonald House to provide housing for families of very sick children.

Many of the clinical research programs involve national cooperative groups such as the Southwest Oncology Group, Radiation Oncology Group, Pediatric Oncology Group, Gastrointestinal Tumor Study Group, National Prostatic Cancer Program and Adjuvant Head & Neck Cancer Program.

These groups range from as few as five institutions to as many as 40; all groups share in common the goal of providing high quality interdisciplinary clinical trials. Faculty from this University play several leading roles in designing the clinical trials. Significant advances have been made in areas such as testicular cancer, soft tissue sarcomas, and colo-rectal cancer as a result of our efforts.

Doctor Baker is coordinator for Cancer Programs, Department of Oncology, Wayne State University, and is deputy director of the Comprehensive Cancer Center. Ms. Yee is administrative assistant to Doctor Baker.

Another major program is in drug development. WSU faculty are the recipients of three large contracts with the National Cancer Institute to develop new agents for combating human malignancies. These efforts are aided by laboratories in pharmacokinetics and human tumor stem cell assay analysis. The main support for this program is through the National Institute of Health. Additionally, this program is also actively supported by members of the pharmaceutical industry, to develop not only anti-cancer drugs but also new anti-emetics, analgesics and antibacterial antibiotics.

More drugs

Currrently the faculty of WSU are the single largest users of investigational drugs in the world. In part, this is because of the faculty attitude that many of the malignancies found in the American population are not significantly helped by commercially-available drugs. Thus, a major effort continues to discover newer agents that are more effective at controlling the cancers and, equally important, less toxic.

An exciting new approach in this area is with a class of drugs called biologic response modifiers. These drugs, rather than being cytotoxic to cancer and normal cells alike, affect the biology of the cancer cell so as to render the effect of the cancer cell on the host innocuous. Wayne State is a recent recipient of a master contract from the NCI to work in this field. We also have been awarded a patent on a prostaglandin synthetase inhibitor whose antitumor properties were uncovered in the research laboratories of this university. Similarly, we are working on the inter-relationships of drugs that are radiation sensitizers and describing these effects on cytotoxic drugs.

A major area of investigation has been the incorporation of multi-treated modalities in the management of difficult cancers. In the past, WSU has reported on a successful therapeutic strategy for the cure of squamous cell carcinomas of the anus. This work was recently extended to squamous cell carcinoma of the esophagus.

At the 1981 meeting of the American Society of Clinical Oncologists, WSU reported initial results that conclude with our expectation of treating larger numbers of patients with this disease, heretofore considered incurable. The basis of treatment is the incorporation of surgery, radiation therapy and chemotherapy in a maximal manner. WSU has reported similarly successful efforts in the management of head and neck cancers. We are planning now to incorporate our findings from our biologic response modifier program into our multi-modal approaches. We have begun planning with industry to investigate new modes of drug delivery systems that will allow drugs to be delivered and targeted to specific organs or tissues rather than systemic usage, thus maximizing the therapeutic index of these agents.

In pre-clinical areas, work continues in studying the immunologic efforts of prostate cancer and childhood leukemia. These nationally-respected efforts continue to unravel the complexities of human tumor biology. Other notable areas of laboratory investigations include clinical carcinogenesis, particularly of colonic carcinoma; study of proteases such as the cathepsins to help distinguish locally aggressive cancers, synthesis of new anti-cancer hormones, and many others.

Cancer Center

Through a common agreement, the University and the Michigan Cancer Foundation formed the Comprehensive Cancer Center of Metropolitan Detroit. This comprehensive cancer center is one of 20 such funded centers in the United States. The most proximal other comprehensive cancer centers are in Chicago and Columbus, Ohio. To qualify for this designation, excellence was required in laboratory investigation, clinical research and care, cancer control programs and educational programs. Some of the programs of the Detroit cancer center have begun to have statewide implication, such as the cancer control efforts and the education programs. Among the major cancer control programs included are the organization of the statewide program to investigate the anti-emetic properties of marijuana; the organization and development of the first hospice program in metropolitan Detroit and the establishment of a multidisciplinary pain clinic at the University Health Center.

Another major element of the cancer center is the population-based cancer registry and epidemiology program. The registry has cancer incidence, mortality, survival and therapy information for the tri-county metropolitan area (Wayne, Macomb, Oakland) since 1969 and has registered more than 200,000 cancer patients. A major epidemiologic program is the study of 147,000 automobile assembly plant workers to study the occupational risks of cancer.

In summary, the cancer program of this University, in concert with the Detroit Medical Center and the Michigan Cancer Foundation, demonstrates in a major way the concerns and dedication of this University faculty and administration in helping to solve a major health problem of the people in the State of Michigan.

(References are available from the authors.)

Advance against prostate cancer

A relatively new surgical procedure offers the possibility of a nearly normal continued life for some men suffering from prostate cancer. Prostate cancer is second only to lung cancer as a killer of men in the United States.

According to Henry Ford Hospital's Chairman of Urology Joseph C. Cerny, MD, who is also a clinical professor of urology at the University of Michigan, "a relatively new surgery involving a less radical operation coupled with the implanting of radioactive seeds into the prostate offers a new option for the patient whose cancer is confined to the prostate and is not spreading. This accounts for about 15 percent of our prostate cancer patients.

"This procedure is a particularly viable option for the younger and middle-aged man."

The two-hour surgical procedure is called an "extended pelvic lymphadenectomy with I-125 implant."

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When **impotence** is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Recent major breakthrough announced by U-M's growing clinical research faculty

By Albert F. LoBuglio, MD, Ann Arbor

The infusion pump, whose use to fight liver cancer was pioneered at The University of Michigan, is implanted just under the skin in the abdomen. The pump permits very high concentrations of anti-cancer drugs to be administered directly to the cancer in the liver, thus prolonging life.

Over the past five years, the University of Michigan has had a major influx of clinical faculty dedicated to cancer research. These clinical investigators have been drawn from the major cancer programs in the nation and have joined with the faculty already in place to generate new efforts in cancer care and research. These efforts are varied and involve multiple specialties concerned with cancer care.

Doctor LoBuglio is professor of internal medicine; director, Division of Hematology and Oncology, and director, Simpson Memorial Research Institute, The University of Michigan.

Liver breakthrough

William Ensminger, MD, (medical oncology) directs our clinical pharmacology efforts in cancer. He has a special interest in regional therapy of malignant disease.

He and John Niederhuber, MD, (surgical oncology), have developed a regional therapy program for primary or metastatic tumors of the liver using hepatic artery infusion via a surgically implanted pump which allows the patients to be fully active and at home while receiving continuous hepatic drug infusion.

This program is also developing new agents for hepatic artery therapy as well as pioneering the use of microspheres for alteration of drug transit in the liver. Glen Kindt, MD (neurosurgery) and Ensminger have developed a similar program for the post-surgical treatment of malignant brain tumors. These studies involve the use of carotid artery infusions of drugs to maximize effects on this tumor which does not usually metastasize and is therefore an excellent candidate for regional therapy.

Doctors Charles Krause, MD, and

continued on page 400

West Bloomfield's most fashionable address. Most people can only afford to dream about the festyle a select few can afford o luxuriate in. Pine Lake Forest ownhouse condominiums are magnificently set upon the shores overlooking the crystal water of ine and Orchard Lakes.

Features like these are standard to each unit: private elevator, cathedral ceiling, Roman tub with acuzzi, electronic air cleaner and humidifier, two-car garage with wo additional parking spaces, elf-cleaning oven with built-in microwave top, sophisticated ecurity system. Even your own boat slip.

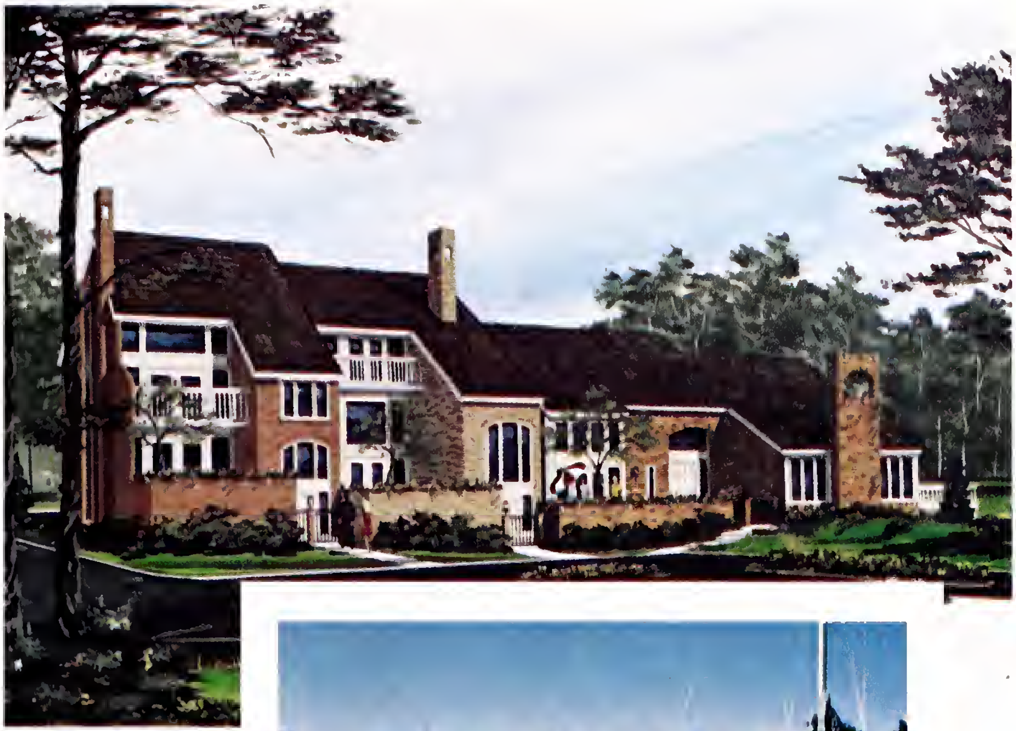
Pine Lake Forest represents ultra-luxury for people who have earned it.

Dramatic. Intimate. Original. Opulent. Mere adjectives unable o capture these home's quintessence.

They are, simply, to become West Bloomfield's most fashionable address. If you are among he select, let us personally introduce you to them.

2 & 3 Bedroom Units
Appropriately priced
unrise Model from $390,000.
unset Model from $555,000.
rices subject to change without notice

Sales Office
300 Orchard Lake Road
North of Long Lake Road
13/681-8666 or 855-5522
Open 2 to 8 Daily



Artist's conception

Lakeview in West Bloomfield

Pine Lake Forest
Townhouse condominiums

Subsidiary of Knoll Enterprises, Inc.

Shan Baker, MD, (ENT Department) have a broad program for care and research in head and neck tumors. They are running studies on the efficacy of adjuvant therapy in patients who present with locally advanced tumors. Together with Richard Wheeler, MD (medical oncology), they are examining the use of regional perfusion of unresectable primary tumors. In addition, their immunology research laboratory, under the direction of Thomas Carey, PhD, is establishing primary cell cultures from patients and exploring the patients' antitumor immune response.

Doctor Wheeler is director of the National Cancer Institute Clinical Trials contract at University Hospital. This program involves the utilization of new investigational drugs or drug combinations for diseases or stages of disease where current therapy is of limited value. These studies are each coordinated by individual faculty members and include programs for the primary therapy of inoperable lung cancer (Ronald Natale, MD), metastatic colon cancer (Doctor Ensminger), recurrent head and neck cancer (Doctor Wheeler), non-Hodgkin's lymphoma for poor prognosis histology (Lyubica Dabich, MD), recurrent bladder cancer (Doctor Natale), as well as programs for disorders resistant to first line chemotherapy including breast cancer (Doctor Wheeler), lymphoma (Doctor Liepman) and leukemia (Kenneth Zuckerman, MD).

Agar cloning

A new development in cancer therapy is the use of soft agar cloning of patients' tumors to determine sensitivity of the tumor to standard or investigational drugs. Doctor Natale directs the tumor cloning laboratory which is investigating the use of this technique for better selection of drugs for therapy of patients having tumors accessible for cloning. This is especially applicable to patients with malignant effusions but can also be done with surgically resected tumors or biopsies of tumors. A new application of this technique is being carried out by Bart Grossman, MD, (urology) and Doctor Natale using bladder washings from bladder cancer patients (local disease) for drug testing prior to local drug therapy (bladder instillation).

William Beierwaltes, MD, (nuclear medicine) coordinates research activities directed at the detection and localization of malignant tumors. In addition to his department's long term program for diagnosis and therapy of thyroid tumors, they have recently received national recognition for development of new technology for detection and localization of adrenal tumors. This group also has a major program directed at the application of monoclonal antibodies for delivery of radioactive isotopes to tumor sites for both diagnostic imaging as well as potential radiation therapy effects.

The recent recruitment of Ray Ruddon, MD, from the National Cancer Institute as chairman of the Department of Pharmacology will further our research efforts in cancer diagnosis. He has a major research effort in the area of tumor markers which may be used to detect or maintain for the presence of malignant cells. These tumor markers include hormones, circulatory peptides and other tumor products.

Immune defenses

Studies on immune defense mechanisms in cancer patients are being carried out by Albert F. LoBuglio, MD, and Thomas Huard, MD, (hematology/oncology). These studies include the effects of immune modulators on cellular cytotoxic mechanisms (e.g., interferon). In collaboration with John Voorhees, MD, they are also examining the effects of vitamin A on human immune defense mechanisms.

The institution participates in several national cooperative group activities including the Southwest Oncology Group (adults) and the Children's Cancer Study Group (pediatrics). The University Hospital has a hematology/oncology subspecialty unit of 30 private rooms for inpatient evaluation and therapy as well as an ambulatory unit for outpatient clinical care and research. Both these units are staffed by oncology nurses, social workers, clinical pharmacists and other vital support personnel to assure quality care.

The institution is involved with several outreach programs involving oncologists and other physicians in surrounding communities as regards to collaborative patient care and research.

The University has a major commitment to the continued expansion of cancer research efforts both in the clinical and basic science arenas

---

U-M finds new way to detect tumors in adrenaline tissues

University of Michigan medical researchers reported in the July 2 *New England Journal of Medicine* that they have successfully developed a new radioactive tracer compound which can detect, for the first time, potentially lethal tumors in the body's adrenaline producing tissues.

The U-M scientists found these tumors in the adrenal gland medulla and on the sympathetic nerves throughout the rest of the body.

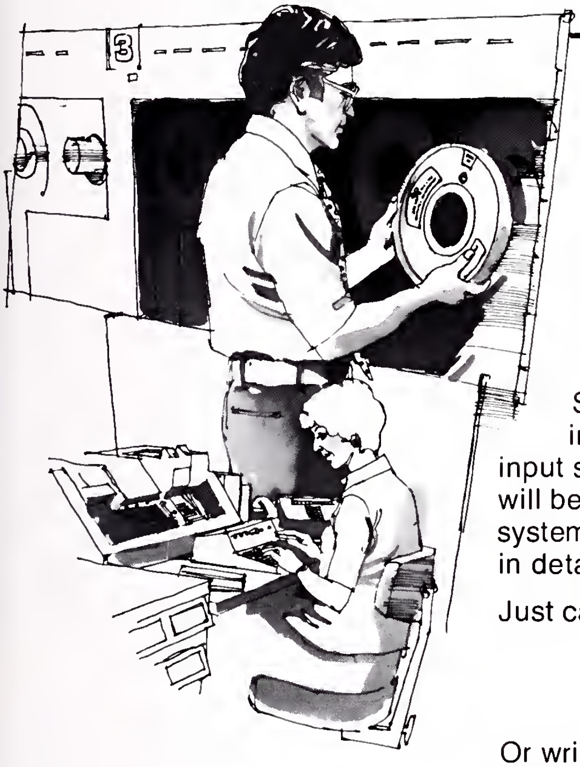
These sometimes malignant growths can flood the body with very high levels of adrenaline and adrenaline-like hormones and are the direct cause of hundreds of deaths in the United States each year due to massive strokes or heart failure.

Labeled with a weak tracer dose of radioactive iodine, the new compound is called 131-I meta-iodobenzylguanidine (MIBG). It was synthesized by Donald M. Wieland, PhD, an organic chemist and head of research and development in nuclear pharmacy at the U-M division of nuclear medicine. MIBG's ability to concentrate in adrenergic (adrenaline producing) tissues makes the tumors visible to sensitive gamma camera scanner equipment outside the body.

The resulting nuclear medicine images or pictures can direct surgeons to the precise point in the body for removal of the tumors.

Reporting on the new MIBG compound in the *Journal* were U-M scientists James C. Sisson, MD; Marc S. Frager, MD; Timothy W. Valk, MD; Milton D. Gross, MD; Dennis P. Swanson, MD; Dr. Wieland; Michael C. Tobes, PhD; William H. Beierwaltes, MD, and Norman W. Thompson, MD.

Use automated input to cut your paperwork, speed up claims payment



Whether you have your own computer or are working with a service bureau, and especially if you are still processing all your claims manually, the Blue Cross and Blue Shield of Michigan Automated Input System is worth looking into. Our automated input staff representatives will be pleased to explain the system's many advantages in detail.

Just call:
313-225-0056
313-225-0039
313-225-0042

Or write:
Blue Cross and Blue Shield of Michigan
Automated Input Department J308
600 Lafayette East
Detroit, Michigan 48226

It's good to belong.

**Blue Cross
Blue Shield**
of Michigan

Interferon in Michigan

By Jeffrey Rich, special to Michigan Medicine

Michigan has five major interferon development, treatment and study projects underway. They are centered in the universities, Michigan Department of Public Health; Michigan Chapter, American Red Cross, and the drug companies.

These projects place Michigan in the mainstream of cancer research and treatment efforts.

MSU, MDPH, ARC project

The Michigan State Department of Public Health, Michigan State University, and American Red Cross are pooling resources to produce and monitor the application of interferon to selected cancer patients across the state. John Mitchell, MD, Chief of Biologic Products Program at the Department of Public Health says the goal of the consortium project, entitled "Interferon For Michigan," is to "statistically standardize the interferon product and its results in a well-controlled clinical trial."

The Red Cross is providing 75 units of buffycoats per week to the DPH, where Doctor Mitchell's team is duplicating the methodology established by Dr. Kari Cantell of Helsinki, Finland. This calls for the production of approximately one million units of interferon per buffycoat. Antiviral assays, the basic potency testing, will be done at the DPH, as well as exchange of samples with Doctor Cantell's Central Public Health Laboratory in Finland.

Under direction of Nikolay Dimitrov, MD, MSU laboratories will receive the DPH interferon, perform in vitro experiments and manage the application of the drug at seven sites across the state. A total of 80 patients, all unresponsive to previous therapies, will be administered interferon. In the initial stages of the project, injections will be made at the tumor site only, with participating doctors following an outlined protocol of injection site, dosage, and schedule, to allow maximum control over the study of tumor reaction to interferon in measured amounts.

Five types of cancer will be studied: lymphoma, leukemia, ovarian carcinoma, mesothelioma, and breast. No charges will be assessed any of the patients, with all funding coming from the sponsoring agencies. The first phase of injections were to be completed in June.

WSU project

A $1,000,000 contract to produce and study interferon has been awarded to a Wayne State University School of Medicine professor by National Geno Sciences, Inc., Southfield.

The primary objective of the one-year research project is to produce and purify human leukocyte interferon to use in local hospitals. Principal Investigator is Lily A. Jones, PhD, assistant professor of immunology and microbiology.

In Doctor Jones' study, interferon will be produced in laboratories in Gordon H. Scott Hall in the Detroit Medical Center. More than half the contract funds will go to the Red Cross to purchase plasma and white cells.

National Geno Sciences, Inc. is an incorporated group of physicians interested in genetic engineering.

Sparrow Hospital project

E. W. Sparrow Hospital of Lansing is engaged in a cancer treatment program utilizing interferon of their own production in conjunction with conventional modes of therapy. Ten cancer patients are currently being administered the interferon with a total of 50 anticipated by the project's completion. Directing the program are immunohematologist W. E. Maldonado, MD, and Medical Oncologist Francis Breen, MD.

In an extension of work already done at Sparrow, leukopheresis is employed to obtain lymphocytes, the essential white blood cell needed to make interferon. Doctor Maldonado claims this process allows for greater recovery of lymphocytes as compared to other blood collection procedures. With the pheresis instruments, as well as the experience to perform natural killer cell assays and grow tumors in semi-liquid mediums for drug-sensitivity testing, Doctor Maldonado feels Edward W. Sparrow Hospital is well-equipped to evaluate patients receiving interferon.

Patients selected for the four-weeks-to-six-months treatment regimen must meet the requirements of the research protocol approved by the hospital's Institutional Research Review Committee. The majority of patients will have one of four types of cancer — breast, multiple myeloma, malignant melanoma, or non-Hodgkin's lymphoma. All patients have histories of previous treatment. Cost to the patients will be approximately $2,000 each, although fee waiving will be used for those who cannot afford it. "Inability to pay will not prevent a person from receiving interferon," says Doctor Maldonado.

Parke, Davis project

Parke, Davis & Company of Detroit is under contract with the National Cancer Institute to produce 50 billion units of interferon by August of this year. The 18-month project, budgeted at $890,000, will not be continued at Parke, Davis in the future, according to Robert Brackett, MD, Director of Clinical Immunology. Doctor Brackett said that there is a phasing-down of biological products work at Parke, Davis.

Along with Microbiologist William Beardmore, MD, Doctor Brackett is duplicating Cantell's methodology in producing interferon from human leukocytes. Parke, Davis will perform their own antiviral assays, and submit samples to Sloan-Kettering and Bioassay Systems Corporation for further testing. NCI will use the interferon for clinical studies.

Upjohn project

The Upjohn Company, Kalamazoo, has been conducting interferon research over the past eight years, according to Dale A. Stringfellow, PhD, research associate at Upjohn. The emphasis of the Upjohn work is directed towards in vivo inducement of host interferon production.

Since 1964 it has been known that substances other than viruses can induce interferon production. Upjohn researchers have been working with pyrimidines in attempting to effectively initiate host manufacture of interferon.

110
105
100
95
90
85
You know
what you want
in Step-1
antihypertensive
therapy...

For your hypertensive patients,

Long-acting

Zaroxolyn® gives

(metolazone) Pennwalt

Efficacy

Start with Zaroxolyn because of its unsurpassed effectiveness in Step-1 therapy.[1-4]

Stay with Zaroxolyn because it maintains effectiveness in long-term therapy[1,5,6]. . . and minimizes the need for Step-2 agents.

☐ Zaroxolyn's effectiveness is maintained even in the presence of reduced kidney function[7-9]

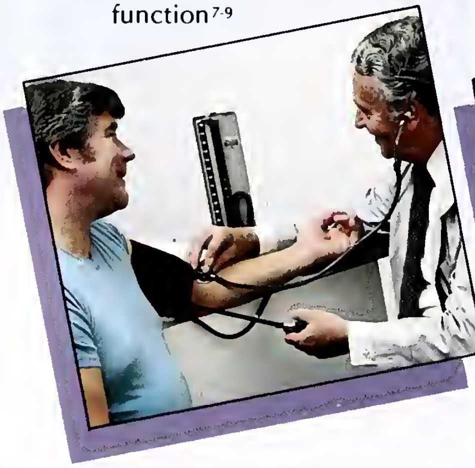
Compliance

Stay with Zaroxolyn because it maintains 24-hour blood pressure control with simple once-daily dosage, and only 4% discontinue therapy due to side effects!

Safety

Stay with Zaroxolyn because clinically significant side effects are rare!

☐ Low incidence of changes in serum K+, glucose metabolism, or uric acid levels



you what you want

Compatibility

Add to Zaroxolyn easily if Step-2 agents become necessary.

☐ Permits lower doses of Step-2 agents to minimize side effects

☐ Allows flexible dosage titration, in contrast to fixed-dose combinations

Economy[10]

☐ Less expensive than most other diuretics

☐ More economical than hydrochlorothiazide in fixed-dose combination with triamterene or reserpine/hydralazine

☐ Costs less than beta-blockers

☐ Less expensive than methyldopa, clonidine, or prazosin

27
Monday
April
1981

Start with...stay with...and add to...

Long-acting

Zaroxolyn®

(metolazone)

Gives you what you want in Step-1 antihypertensive therapy

Please see following page for prescribing information.

NAME
ADDRESS
DATE
℞
Zaroxolyn
REFILL..........TIMES
NON REPETATUR ☐
Address

Long-acting

Zaroxolyn®
(metolazone) Pennwalt

2½ mg, 5 mg, 10 mg tablets

Gives you what you want in Step-1 antihypertensive therapy

- ☐ Unsurpassed Step-1 efficacy in mild to moderate hypertension
- ☐ True once-daily dosage for excellent patient compliance
- ☐ Positive side effect profile
- ☐ Strong foundation for stepped-care therapy
- ☐ Long-term economy

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma, allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions**: Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied**: Tablets, 2½, 5 and 10 mg

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton, 1976, pp 221-245. 3. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puschett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book 1981*, and manufacturers' suggested prices.

℞ DIVISION
PENNWALT
ROCHESTER NEW YORK 14623

A-297

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Beatriz E. Amendola, MD TR
3950 Kipling Drive
Ann Arbor, MI 48105

Alan D. Bersted, MD IM
545 S. Fifth Avenue
Ann Arbor, MI 48104

John G. Bizon, MD GP
522 Invader
KI Sawyer AFB, MI 49843

Steven Bolton, MD GS
15619 Addison
Southfield, MI 48075

Paul E. Braman, MD FP
8194 Byron Center Ave.
Byron Center, MI 49315

Wayne J. Breece, MD IM/CD
7492 River Road
Flushing, MI 48433

George O. Brick, MD EM
Oakwood Hospital
Dearborn, MI 48124

Allan C.D. Brown, MD AN
U of M Hosp. S6344 Box 043
Ann Arbor, MI 48109

Louis J. Cannella, MD GP
559 Chandler
Chelsea, MI 48118

Lucian F. Capobianco, MD FP
22151 Moross Rd.
Detroit, MI 48236

Byung Ho Chang, MD DR
2710 W. Court St. #12
Flint, MI 48503

Ronald S. Cirone, DO EM
461 W. Huron St.
Pontiac, MI 48053

Gary C. Courville, MD IM
4200 Fashion Square Blvd.
Saginaw, MI 48603

Jack L. Cronenwett, MD GS
U of M Medical Ctr.,
Dept/Surgery
B4963
Ann Arbor, MI 48109

William F. Cushman, MD GS/OM
3200 Cabaret Trail, So.
Saginaw, MI 48603

Norma C. Derro, MD PD
6117 Laurain St.
West Bloomfield, MI 48033

Richard S. Duff, MD OBG
145 Rockdale Dr.
Rochester, MI 48063

Aubrey C. Elkins, Jr., MD PD
3250 Plymouth Rd.
Ann Arbor, MI 48105

David L. Freedman, MD FP
14002 Foxtrail
Holland, MI 49423

Jeffrey J. Freitag, MD IM/NEP
1447 N. Harrison
Saginaw, MI 48602

Yvonne M. Friday, MD PD
23311 W. 8 Mile Rd. #308
Detroit, MI 48219

George B. Goris, MD IM
S. Washington Med. Center
Holland, MI 49423

Steven L. Gotlib, MD P
2200 Fuller Rd. #309
Ann Arbor, MI 48105

Sarita Gupta, MD PTH
Pontiac General Hospital
Pontiac, MI 48053

Abdul Haq, MD PD
307 Ecorse Rd.
Ypsilanti, MI 48197

David S. Hollett, MD FP
150 Walton Blvd.
Rochester, MI 48063

Roger J. Hucek, MD TRS/CDS
1414 W. Fair Ave.
Marquette, MI 49855

Gary N. Humphries, MD IM
1900 Wealthy St., SE
Grand Rapids, MI 49506

Riad G. Khoury, MD A
16000 W. Nine Mile Rd.
Southfield, MI 48075

Hae Sook Kim, MD TR
2710 W. Court St. #12
Flint, MI 48503

David A. Krause, MD TR
Edw. Sparrow Hosp. Radiology
Lansing, MI 48909

Elwood H. LaBrosse, MD IM
529 E. Cedar St.
Standish, MI 48658

James R. Mac Kenzie, MD GS
1405 Ann St., C4020 — Outpatient
Ann Arbor, MI 48109

Bruce W. Nugent, MD EM
2473 Woodlake, SW
Wyoming, MI 49509

Dimitri S. Pallas, MD CD
4839 Middlesex
Dearborn, MI 48126

Haresh B. Pandya, MD PD/FP
101 Northcrest Centre
Lansing, MI 48906

K. H. Pardanani, MD PD
15509 Heyden
Detroit, MI 48223

Michael J. Parks, MD ORS
551 Linn St.
Allegan, MI 49010

Jagadish M. Prasad, MD IM
1447 N. Harrison
Saginaw, MI 48602

Robert A. Radin, MD EM/FP
7800 Peninsula Dr.
Traverse City, MI 49684

William H. Raino, MD N
1717 Shaffer Rd. #229
Kalamazoo, MI 49001

William W. Resinger, MD R/NM
1847 Manchester Dr.
Ypsilanti, MI 48197

Siva V. Sankaran, MD IM
1222 Vincent Ave. #17
Flint, MI 48503

David R. Schleif, MD EM
Oakwood Hospital — Emergency
Dearborn, MI 48124

James R. Smith, MD IM/GP
820 Arlington Ave.
Petoskey, MI 49770

Laurence E. Stawick, MD GE/IM
22250 Providence Dr. #604
Southfield, MI 48075

William E. Strodel, MD GS
U of M Med. Ctr. B4963
Ann Arbor, MI 48109

Pacita Li Tanhehco, MD PD/AI
3346 Ivory Rd.
Hadley, MI 49440

---

continued on page 408

Michigan Board of Medicine disciplinary actions

May 29 to July 2, 1981

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized:

- **Curtis Lee Frazer, MD**

687 E. Empire
Benton Harbor, 49022

Date, action taken

May 6, 1981
Probation from 5-6-81 to 5-6-83

Violation

S.16221(a) — Condition which impairs the ability to safely and skillfully practice.
S.16221(b) (iii) — Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

- **David C. Mitchell, MD**

271 Hillcrest
Grosse Pte. Farms, 48236

Date, action taken

May 6, 1981
Probation from 5-6-81 to 5-6-83

Violation

S.16221(a) — Condition which impairs the ability of licensee to safely and skillfully practice.
S.16221(b) (iii) — Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

- **Michael S. Quadir, MD**

4004 Lake Drive, R#3
P.O. Box 157
Allegan, 49010

Date, action taken

May 6, 1981
Reprimand and Probation from 5-9-81 to 5-9-83

Violation

S.11(n) — The obtaining of, or attempting to obtain, money or any thing of value by fraudulent misrepresentations in the course of practice.

- **Edward J. Stehouwer, MD**

Blodgett Memorial Medical Ctr.
Grand Rapids, 49506

Date, action taken

May 6, 1981
Reprimand and Probation from 7-1-81 to 7-1-82

Violation

S.16221(c) (iv) — Prescribing, obtaining and possessing a controlled substance by subterfuge, and his prescribing, giving away or administering of these drugs without a lawful therapeutic purpose.

- **John M. Trudeau, MD**

18.61 W. 12 Mile Rd., Ste. 7
Lathrup Village, 48076

Date, action taken

May 6, 1981
Licensee Placed on Limited License on 5-15-81

Violation

S.16221(a) — Failure to exercise due care.
S.16221(b) (i) — Incompetence.
Complaint Dismissed without prejudice.

- **Ronald C. Zajac, MD**

11458 McDougall
Hamtramck, 48212

Date, action taken

Summarily Suspended effective 11-10-80

Violation

S.16221(b) (ii) — Substance abuse.
S.16221(b) (iii) — Mental or physical inability reasonably related to and adversely affecting his ability to practice in a safe and competent manner.
S.16221(c) (iv) — Administering drugs for other than lawful diagnostic or therapeutic purposes.

- **Lendall D. Archer, MD**

902-F Montevideo Drive
Lansing, 48917

Date, action taken

June 17, 1981
Complaint Dismissed upon the Permanent Surrender of License

Violation

S.16221(c) (iv) — Providing excessive quantities of controlled substances upon request for a third person, and prescribing or giving away large quantities of a controlled substance in exchange for another controlled substance.

- **Albert T. Lozon, MD**

Woodward Industrial Center
47 Piquette
Detroit, 48202

Date, action taken

June 17, 1981
Limited License from 6-17-81 to 6-17-82

Violation

S.16221(d) (i) — False and misleading advertising.
S.16221(g) & S.17040(1) — Did utilize or supervise a physician's assistant in the practice of medicine without first obtaining written approval from the Board.

NEW MEMBERS/*continued*

Wayne A. Taulbee, MD OPH
114 W. North St.
Owosso, MI 48867

Philip L. Van Lenti, MD FP
922 Oakdale Ct.
Holland, MI 49423

Ronald J. Van Valkenburg, MD
1675 Leahy #304 CHP/PD
Muskegon, MI 49442

Richard O. Wagner, DO EM
30041 DeOrr
Farmington Hills, MI 48018

Walter M. Whitehouse, MD CDS/GS
U of M Med. Ctr. B4960
Ann Arbor, MI 48109

Edward H. Whitelock, MD FP
2901 West Rd.
Trenton, MI 48183

Gregory T. Wolf, MD OTO
2215 Fuller Rd., VA Med. Ctr.
Ann Arbor, MI 48105

Douglas R. Woll, MD IM
19401 Hubbard Dr.
Dearborn, MI 48126

Pluto K. Wong, MD IM
640 N. Woodward #101
Birmingham, MI 48011

Alkis P. Zingas, MD R
2063 Hyde Park
Detroit, MI 48201

works well in your office...

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.
- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Arthroscopic surgical center after one year: a consumer item, it draws much attention

By Kim White, special to Michigan Medicine

Reporters observe arthroscopic surgery underway at Lansing's year-old clinic, which has drawn much public attention.

It threatens to outdate certain traditional surgical procedures and many physicians find it difficult to keep up with patient demand for it.

This important new medical advance is arthroscopic surgery, one of the fastest growing sub-specialties in medicine today.

The growing need for arthroscopic surgery instruction for physicians has nearly surpassed the current opportunities orthopedic physicians have to learn and improve their arthroscopic surgical skills.

First anniversary

Meeting the educational needs of a select number of practitioners is the arthroscopic surgical center at Ingham Medical Center in Lansing. Celebrating its first year anniversary, the center continues to hold the honor of being the only one of its kind in the United States and the world.

Lannie Johnson, MD, and David Shneider, MD, local orthopedic surgeons, first envisioned the center in the early '70s. Since then, they and Michael Austin, MD, have made impressive in-roads into the field. They have created an altogether new sub-specialty — arthroscopic surgery.

"I foresee arthroscopic surgery will be the biggest sub-specialty in orthopedics," contends Doctor Johnson, who has become internationally-reknowned. In their first year, Doctor Johnson and his associates have performed nearly 2,000 surgeries at the center, using their new techniques and recently developed instruments.

Before the founding of the center, arthroscopic surgery at Ingham Medical Center was performed in an operating room in the surgical department of the hospital. Originally, with many other demands for the use of the same operating and recovery rooms, this sometimes meant a delay for the patient and physician.

Why sub-specialty?

What compelled Doctor Johnson to take steps to make arthroscopy a sub-specialty?

According to Doctor Johnson, " . . . inaccurate diagnosis of problem joints. . . . " was the main factor in his initiation of "direct diagnosis" through greater use of the more precise arthroscope.

"In the past, doctors would merely talk with patients and obtain what I call circumstantial evidence; this just isn't enough any longer," Johnson says, "The arthroscope can give us a diagram of what we need to know for surgery."

Another reason for his pursuit of arthroscopy as a specialty is the obvious healing advantage of a puncture wound over a six-inch incision.

Lastly, arthroscopic surgery patients are spared conventional surgery and many save both money and time. Open knee surgery usually requires a three to five day hospital stay, compared to arthroscopic surgery which requires a hospital stay of only a few hours on the average.

"We're definitely a consumer item," Doctor Shneider proudly points out.

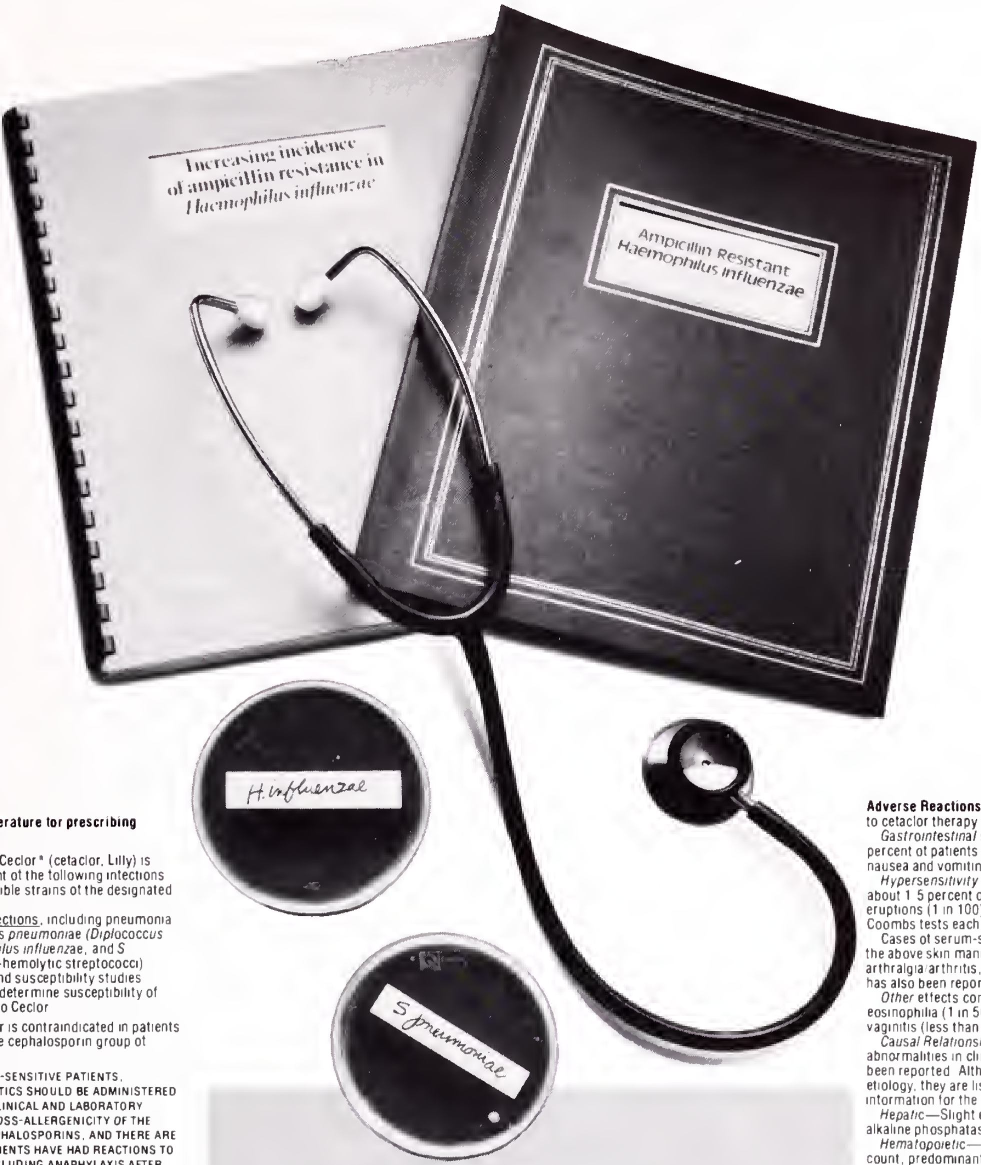
And indeed, in its opening weeks the center was deluged with thousands of calls and letters from people with joint problems looking for an alternative solution to traditional open-knee surgery.

Success rate

The success rate of the center's procedures has yet to be measured on the basis of follow-ups. The medical community usually insists on two years of patient follow-up before results are fully accepted as credible.

continued on page 412

An added complication...
n the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

riet Summary.
onsult the package literature for prescribing formation.

dications and Usage: Ceclor® (cefaclor, Lilly) is dicated in the treatment of the following infections hen caused by susceptible strains of the designated icroorganisms

Lower respiratory infections, including pneumonia used by *Streptococcus pneumoniae (Diplococcus eumoniae)*, *Haemophilus influenzae*, and *S ogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies hould be performed to determine susceptibility of e causative organism to Ceclor

ontraindication: Ceclor is contraindicated in patients th known allergy to the cephalosporin group of tibiotics

arnings: IN PENICILLIN-SENSITIVE PATIENTS, PHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED AUTIOUSLY THERE IS CLINICAL AND LABORATORY VIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE NICILLINS AND THE CEPHALOSPORINS, AND THERE ARE STANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO OTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER ARENTERAL USE)

Antibiotics, including Ceclor, should be administered utiously to any patient who has demonstrated some rm of allergy, particularly to drugs

recautions: If an allergic reaction to cefaclor occurs, e drug should be discontinued, and, if necessary, the tient should be treated with appropriate agents, e g , essor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the vergrowth of nonsusceptible organisms Careful bservation of the patient is essential If superinfection ccurs during therapy, appropriate measures should e taken.

Positive direct Coombs tests have been reported uring treatment with the cephalosporin antibiotics In ematologic studies or in transfusion cross-matching ocedures when antiglobulin tests are performed on e minor side or in Coombs testing of newborns hose mothers have received cephalosporin antibiotics efore parturition, it should be recognized that a sitive Coombs test may be due to the drug

Ceclor should be administered with caution in the esence of markedly impaired renal function. Under uch a condition, careful clinical observation and boratory studies should be made because safe osage may be lower than that usually recommended

As a result of administration of Ceclor, a false-sitive reaction for glucose in the urine may occur his has been observed with Benedict's and Fehling's olutions and also with Clinitest® tablets but not with es-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or ntifertility effects were seen in reproduction studies mice and rats receiving up to 12 times the aximum human dose or in ferrets given three times e maximum human dose, the safety of this drug for se in human pregnancy has not been established he benefits of the drug in pregnant women should e weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in fants less than one month of age has not been stablished

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [103080R]

---

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* [8]

Note Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

1 Antimicrob Agents Chemother , *8* 91, 1975
2 Antimicrob Agents Chemother , *11* 470, 1977
3 Antimicrob Agents Chemother , *13* 584, 1978
4 Antimicrob Agents Chemother , *12* 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880 Washington, D C American Society for Microbiology, 1978
6 Antimicrob Agents Chemother , *13* 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr , and J E Bennett), p 487 New York John Wiley & Sons, 1979

Lilly

100061

Additional information available to the profession on request from
Eli Lilly and Company,
Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

ARTHROSCOPIC/*continued*

Since the center has been open for just one year, to obtain the most accurate and professional results a computer recently was purchased and people hired to establish results on a sound pathological basis.

But according to Doctor Johnson, "We wouldn't be here if we weren't successful."

Other physicians and medical technicians must agree, as nearly every morning there are at least a half-dozen professionals in the observation room to watch Johnson perform surgery and ask questions on a phone connected to the operating room.

The operating room itself, a former obstetrical suite, was renovated and now resembles a recording studio fully equipped with television monitors and glass-enclosed observation area. Television monitors magnify the inside of a patient's knee sometimes 15 times its true size, displaying the colorful cave-like joints.

Physicians from many areas of the United States and some from other countries visit to observe Doctors Johnson and Shneider's techniques first hand. Patients also come from all over the country and many include well-known sports personalities.

"At this point we're on the bottom floor of (arthroscopy). We pick and choose what we want to do, and in fact set the standards for the future," Doctor Shneider says.

Arthroscopic instruction

Any physician can obtain arthroscopic instruction by visiting the center at Ingham Medical, where Doctor Johnson and his associates conduct seven seminars every week.

A major seminar, "Advanced Diagnostic and Surgical Arthroscopy," to be held September 17-18, at the Lansing Hilton, will be given by eight or nine highly-experienced arthroscopic surgeons. The course is by invitation only.

To support educational requests of practitioners from throughout the country, comparison results of surgery at the center are compiled and coordinated by Doctor Shneider through publication of the Video Journal, Inc.

Model T stage

The center has been called by Doctor Johnson, "merely the 'Model-T' of what is possible."

Some parts of that "Model-T" include new surgical procedures developed by Johnson, such as:

- Arthroscopic abrasion chondroplasty, where an instrument, the abrader, abrades the articular cartilage down to the blood supply when the cartilage is damaged and/or partially worn down,
- Arthroscopy patellar stabilizations, where new surgical instruments allow the surgeon to tighten a dislocated knee cap, and
- Exploration of other joints, especially the shoulder.

Shneider predicts arthroscopic rooms will be in every major hospital. "It's just a matter of time."

Johnson goes further: "Although some people may disagree, presently it (arthroscopy) is the point of entry into medicine for patients with sonovial joint problems and it will be the major surgical method for these kinds of cases — the potential is great . . . "

Microbiological Systems for the Physician's Office

- Troy Biologicals offers a variety of culture systems that enable the physician to perform a culture and sensitivity on different specimens (throat, urine, vaginal, wound, skin, etc.).
- *The Quad Plus System* is an all purpose system which includes a (1) quad plate for identification purposes, (2) a Mueller Hinton plate for sensitivity testing, (3) antibiotic discs, (4) swabs and (5) patient report pads. Pricing for the *Quad Plus System* begins at $1.99 per system. Quantity discounts are available.
- Specialized bi-plate and tri-plate systems are also available for throat and urine specimens. Troy Biologicals also offers a complete line of standard plates and tubed media, such as T.S.A. with 5% sheep's blood, E.M.B. agar, MacConkey agar, etc. Contact us for a price quote.
- A complete set-up is available upon request. Troy Biologicals carries a full line of related microbiological supplies such as incubators, loops, alcohol lamps, swabs, culturettes, disc dispensers, etc.
- A *Workshop in Clinical Microbiology* is also available to those who need additional training.
- Call for a complete price list and colored brochure.

TROY BIOLOGICALS, INC.
6107 E. Ten Mile Road • Warren, Michigan 48091
Call Collect: (313) 759-4530

No One Ever Sued Dr. Kildare For Malpractice

It's true. Back in 1962 when Dr. Kildare was one of television's most popular programs, millions of Americans would have been outraged. Richard Chamberlain and Raymond Massey almost always saved the patient and solved so many unusual diagnostic problems that they were our medical heroes.

And they did it without a CT scanner, an SMA 12, and all the other sophisticated technology which fills our hospitals today. Their patients loved them. Their viewers loved them. The drama flickering across America for 60 minutes each Thursday evening reassured us that our medical care was in good hands.

But this is 1981. The Age of Consumerism, Technology, and unfortunately. . . Litigation. US NEWS & WORLD REPORT stated there were 7 million lawsuits in 1978. That's one per every 30 Americans.

We still have our medical heroes. Quincy has been sued once for malpractice and he was an expert witness in another episode. Trapper John was also sued when he rendered emergency aid away from the hospital.

Times have changed. Society has changed. Medical skills, diagnostic expertise, and physicians' knowledge have increased significantly since the days of Dr. Kildare. Yet patients are suing physicians at a frequency which is alarming to the profession.

That's why in 1975, Michigan physicians chose to control their professional liability future by forming the Michigan Physicians Mutual Liability Company (MPMLC). A company owned, controlled, and totally supported by physicians.

MPMLC is your company. It is reacting to the 1980s by providing more coverages, reducing rates — the third reduction in the past four years, and responding to the needs of its insured physicians. Since issuing its first policy in May, 1976, MPMLC has become the second largest writer of medical professional liability coverage in Michigan. . . and the 25th largest in the country.

MPMLC is prepared for the Age of Litigation.

Your Company

Michigan Physicians Mutual Liability Company

P.O. Box 1471
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926 toll free

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Jackson's enterprising Doctor Niekamp organizes "army" for high school physicals

By Larry Edsall, special to Michigan Medicine

Doctor Niekamp examines knee of Jackson seventh grader Paul Varner.

Early each summer, hundreds of boys and girls clad in colorfully-striped T-shirts, shorts and athletic shoes assemble at Lumen Christi High School in Jackson.

They come not to visit their coaches, or to train for teams which have won eight state championships in the past four school years.

They come to see Harold Niekamp, MD, and his medical army, who administer physical examinations to more than 400 high and middle school students in a matter of three hours.

Doctor Niekamp, an orthopedic surgeon, gathers a staff of a dozen doctors, two physical therapists, two orthopedic assistants and 16 registered nurses to administer the annual pre-competition examination required of each athlete who competes in sports events sanctioned by the Michigan High School Athletic Association.

Abnormalities found

"It's nothing like an office exam," said Doctor Niekamp, "but if there is something wrong, we're liable to see it."

It seems each summer the doctors discover a couple of hernias and occasionally a case of spinal scoliosis.

One reason the Lumen Christi physicals are given so early in the summer is that sufficient time is left for treatment before the start of the school year. When such physicals are given late in the summer, as they are at most schools, proper treatment of a correctable problem may keep a student out of competition for much of the fall sports season.

Doctor Niekamp and his staff volunteer their time. Each athlete pays a token $1 fee, which is contributed to the school's athletic department.

"Most of the doctors are connected with the school (by having children in attendance). Or we twist their arms to get them to volunteer their time," said Doctor Niekamp, recipient of Lumen Christi's first James C. Crowley Service plaque.

Crowley, a popular and successful football coach at the school, was killed during an apparent robbery outside his home Jan. 4, 1980. Doctor Niekamp received the first memorial award named in Crowley's honor for his "outstanding and unselfish service to the students of Lumen Christi." Doctor Niekamp has been the Titans' physician for several years.

Exam checklist

Boys and girls are separated for the physicals, although the examinations are similar. Each athlete is tested for blood pressure; undergoes eye, ear, nose and throat examinations; has heart and lungs checked; undergoes an abdominal check and has back, legs and feet checked by Doctor Niekamp or one of the other orthopedic specialists.

One other unusual aspect of the Lumen Christi physicals has female doctors handling part of the girls' examinations. Lumen Christi's examinations involve both the high school's own students as well as those from Jackson Catholic Middle School and many of the girls appreciate the fact that Jackson can supply so many female doctors.

Joining Doctor Niekamp in the examinations this summer were Joe R. Tai, MD; Ron Kornak, MD; Edward Calvelo, MD; James O'Connor, MD; Hilda Habenicht, MD; Andre Michaud, MD; Parviz Samii, MD; physical therapists Ron Symanski and Dick Kohler, and orthopedic assistants Jim Taylor and Paul Weist.

for Knotts in the night

Prescribe new formula

Quinamm*

(quinine sulfate tablets)

each tablet contains quinine sulfate 260 mg

Specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

Merrell Dow

*Trademark of MERRELL-NATIONAL LABORATORIES Inc.,
Cayey, Puerto Rico 00633

Quinamm™

(quinine sulfate tablets)

CAUTION Federal law prohibits dispensing without prescription

BRIEF SUMMARY

INDICATIONS AND USAGE

For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS

Quinamm may cause fetal harm when administered to a pregnant woman Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g) for attempted abortion In about half of these reports the malformation was deafness related to auditory nerve hypoplasia Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys Quinamm is contraindicated in women who are or may become pregnant If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use Recovery usually occurs following withdrawal of the medication and appropriate therapy

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever

WARNINGS

Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision, however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin.

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine Quinamm should be stopped immediately if evidence of hemolysis appears

If symptoms occur, drug should be discontinued and supportive measures instituted In case of overdosage, see OVERDOSAGE section of prescribing information

PRECAUTIONS

General

Quinamm should be discontinued if there is any evidence of hypersensitivity (See CONTRAINDICATIONS) Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine (See Drug Interactions)

Drug Interactions

Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

The effects of neuromuscular blocking agents (particularly pancuronium succinylcholine, and tubocurarine) may be potentiated with quinine, and result in respiratory difficulties

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity

Drug Laboratory Interactions

Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used

Carcinogenesis, Mutagenesis, Impairment of Fertility

A study of quinine sulfate administered in drinking water (0 1%) to rats for periods up to 20 months showed no evidence of neoplastic changes

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test Intraperitoneal injections (0 5 mM kg) were given twice, 24 hours apart Direct *Salmonella typhimurium* tests were negative, when mammalian liver homogenate was added positive results were found

No information relating to the effect of quinine upon fertility in animal or in man has been found

Pregnancy

Category X See CONTRAINDICATIONS

Nonteratogenic Effects

Because quinine crosses the placenta in humans, the potential for fetal effects is present Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown Quinine in toxic amounts has been associated with abortion Whether this action is always due to direct effect on the uterus is questionable

Nursing Mothers

Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts)

ADVERSE REACTIONS

The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage (Individual or multiple symptoms may represent cinchonism or hypersensitivity)

Hematologic acute hemolysis thrombocytopenic purpura agranulocytosis hypoprothrombinemia

CNS visual disturbances, including blurred vision with scotomata photophobia diplopia diminished visual fields and disturbed color vision tinnitus, deafness and vertigo headache, nausea, vomiting fever, apprehension, restlessness confusion and syncope

Dermatologic allergic cutaneous rashes (urticarial the most frequent type of allergic reaction papular or scarlatinal) pruritus, flushing of the skin sweating occasional edema of the face

Respiratory asthmatic symptoms

Cardiovascular anginal symptoms

Gastrointestinal nausea and vomiting (may be CNS-related) epigastric pain

DRUG ABUSE AND DEPENDENCE

Tolerance abuse or dependence with Quinamm has not been reported

OVERDOSAGE

See prescribing information for a discussion on symptoms and treatment of overdose

DOSAGE AND ADMINISTRATION

1 tablet upon retiring If needed 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring

After several consecutive nights in which recumbency leg cramps do not occur Quinamm may be discontinued in order to determine whether continued therapy is needed

Product Information as of October 1980

Licensor of Merrell*

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

Direct Medical Inquiries to

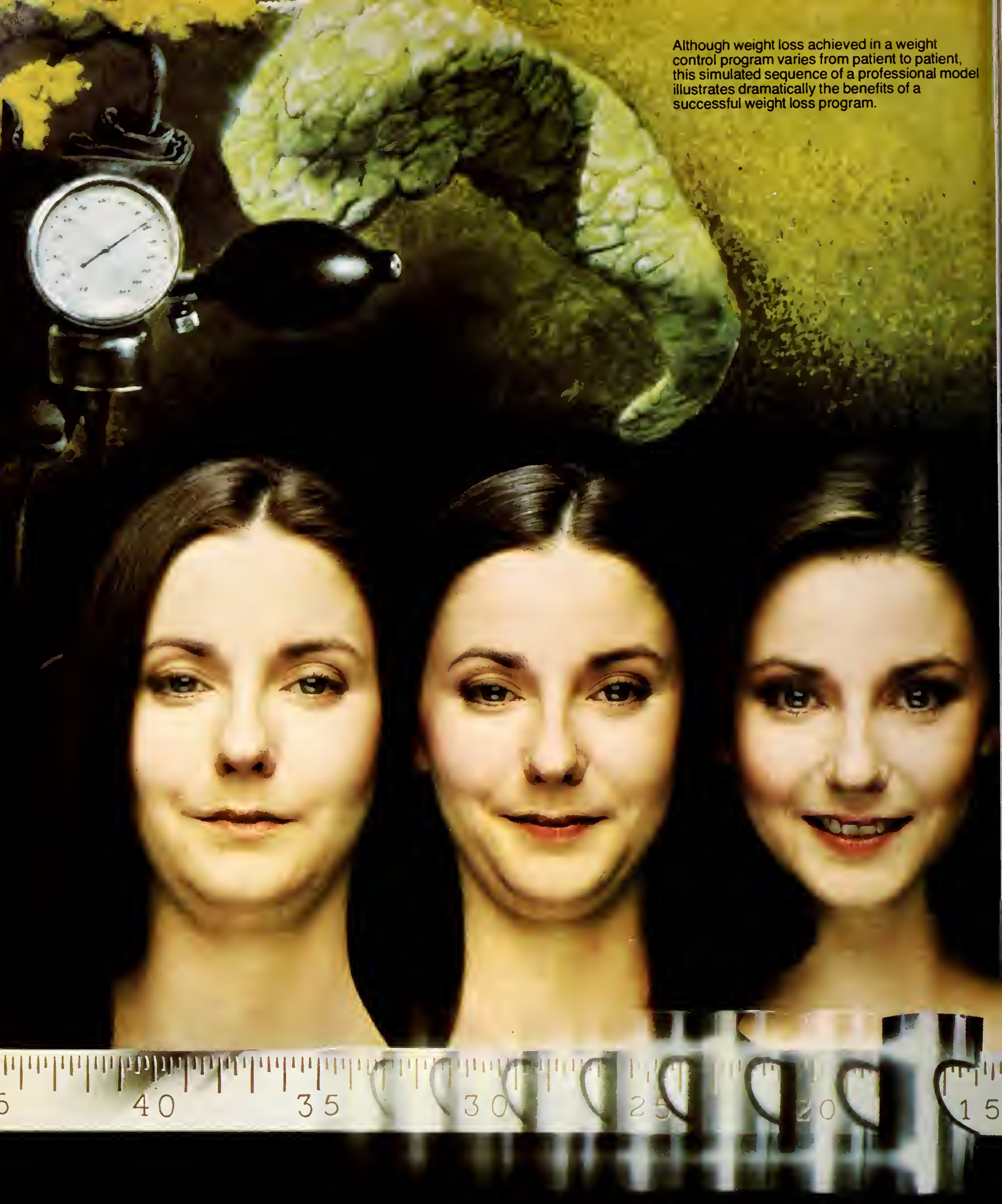
Merrell

DOW

MERRELL DOW PHARMACEUTICALS INC.
Subsidiary of The Dow Chemical Company
Cincinnati, OH 45215, U.S.A.

1-8137 (Y437C)MNQ-699

Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.



getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate* Dospan* ⒸIV

(diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation." [2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate–it makes sense.
And it's responsible medicine.**

Merrell Dow

*Registered Trademarks of MERRELL-NATIONAL LABORATORIES Inc.,
Cayey, Puerto Rico 00633

References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed, New York Raven Press, 1978, pp. 391-404

Tenuate® ⒸIV
(diethylpropion hydrochloride USP)

Tenuate Dospan® ⒸIV
(diethylpropion hydrochloride USP)
controlled-release
AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result)

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personalty changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia *Use in Pregnancy* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children.* Tenuate is not recommended for use in children under 12 years of age

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage Reports suggest that Tenuate may increase convulsions in some epileptics Therefore, epileptics receiving Tenuate should be carefully monitored Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic.* Urticaria, rash, ecchymosis, erythema *Endocrine* Impotence, changes in libido, gynecomastia, menstrual upset *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning Tenuate is not recommended for use in children under 12 years of age

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states Fatigue and depression usually follow the central stimulation Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

Product Information as of June, 1980

Licensee of Merrell®
MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:

Merrell

DOW

MERRELL DOW PHARMACEUTICALS INC
Subsidiary of The Dow Chemical Company
Cincinnati, OH 45215.U.S.A.

1-8164 (Y449C) MNQ-717

Patients sought by U-M for these research projects

Aspirin sensitive asthma: studies of mechanisms of "desensitization"

Recent studies have indicated that following the cautious administration of aspirin to patients who experience asthma from this drug, there is a refractory period during which they remain tolerant. The mechanism of this "desensitization" remains unknown (probably is not immunological), but some of these patients seem to have improvement in their asthma and nasal symptoms if they take aspirin daily following "desensitization."

Patients are needed who have asthma after taking aspirin; many of these individuals also have nasal polyps ("Triad asthma"). The protocol involves an eight-day admission to the Clinical Research Center following some preliminary studies. Costs are provided by a research grant.

Physicians should contact Kenneth P. Mathews, MD, Allergy Clinic, Box 27, University Hospital, Ann Arbor, 48109, (313) 763-3141.

Bacterial and immune studies in Whipple's disease

Patients with untreated Whipple's disease will be admitted to the University of Michigan for a period of two to four weeks. These patients must have been recently diagnosed, and have not received antibiotic treatment and be well enough to permit delay in treatment for the necessary period of study. Acutely ill patients would not be eligible for such a study. The majority of patients with Whipple's disease are not acutely ill and can easily delay treatment for two to four weeks in order to permit these important clinical studies. The patients will be evaluated by routine history and physical, routine laboratory studies, and extensive immunological testing. The key element of the study is to make an effort to successfully culture the bacterial organism thought to be etiologic in this disease.

There will be no charge to the patient for these studies. Physicians should contact William O. Dobbins, III, MD, VA Medical Center, Ann Arbor, 313/769-7100, Ext. 681.

Treatment of sickle cell anemia with zinc and related agents

We are engaged in long-term studies of zinc in combination with various other drugs as a treatment for sickle cell anemia. These drugs protect against the membrane lesion in the sickle cell, reducing the development of irreversibly sickled cells (which are membrane damaged cells). Uncontrolled observations indicate that certain combinations such as zinc and a phenothiazine, reduce pain-crisis frequency.

We are interested in referrals of patients over the age of five years with sickle cell anemia who are available for short hospitalizations, and outpatient clinic follow-up every two weeks, and who are interested in participating in therapeutic trials.

All facets of the studies will be supported by grant funds, including hospitalization and patient transportation.

Physicians should contact George J. Brewer, MD, Dept. of Human Genetics, 3914 Buhl, Ann Arbor, 313/764-5499 or 313/763-3530.

Treatment of Wilson's Disease with zinc

We have found that one side-effect of zinc treatment in sickle cell anemia was zinc-induced copper deficiency. This zinc side-effect is easily controlled by small amounts of copper supplementation. However, we decided to put this accidental finding to use as a potential treatment of Wilson's Disease, an inherited abnormality of copper accumulation. In balance studies in two patients with Wilson's Disease, we have shown that oral zinc therapy will produce a very pronounced negative copper balance. The mechanism involves a zinc-induced increased excretion of copper in the stool, probably by inhibition of copper absorption from food and copper reabsorption from bile.

We would very much appreciate referral of patients with Wilson's Disease. We have in mind three types of studies.

1) Additional short-term copper balance work, to show the general validity of this zinc effect.

2) In those patients in whom balance studies show the effectiveness of zinc, to offer switching over of long term maintenance therapy from penicillamine to zinc, which is much less toxic. Such patients will be carefully monitored for adequate control.

3) In selected patients, trial of zinc as an initial decoppering agent, since it seems to be capable of inducing a much greater negative copper balance than penicillamine.

All facets of our work are NIH-funded, and we can support all financial costs of the studies, including patient transportation.

Physicians should contact George G. Brewer, MD, Dept. of Human Genetics, 3914 Buhl, Ann Arbor, 313/764-5499 or 313/763-3530.

Diltiazem for treatment of patients with pulmonary hypertension

Patients with primary pulmonary hypertension or pulmonary hypertension secondary to emphysema or pulmonary emboli are being treated with diltiazem, a calcium channel blocking agent. After baseline rest and exercise hemodynamic and gas exchange measurements, patients receive intravenous diltiazem and this is followed by repeat measurements. Patients then receive oral diltiazem for eight weeks while they are followed carefully as outpatients. After eight weeks of oral treatment, patients return for repeat hemodynamic and gas exchange measurements. Costs for the drug and patient care (including right heart catheterization) are funded. Results from the initial patients studied have been most encouraging. Patients who are early in the course of their illness are most likely to have reversible disease and benefit the most. The study is conducted jointly by the Cardiology and Pulmonary Divisions at the University of Michigan.

Physicians should contact Barry J. Crevey, MD, Cardiology Division W11612, University Hospital, Ann Arbor, 48109, (313) 763-5255.

Does the rise in the prime rate cause a rise in your blood pressure?

Diamonds
Inflation
2000

International Diamond Corporation
offers fine diamonds, a safe and secure asset for the '80s.

The 1980s promise to be a time of financial insecurity, high inflation, up-and-down gold prices and stock market instability. Only investment quality diamonds offer investors a steady, nonvolatile way to store wealth and increase your investment value.

International Diamond Corporation, the leader in investment diamond services, protects your investment safely and securely with:

- Insured grade accuracy, guaranteed in writing
- 10-year history of successful liquidations (resales)
- Audited records of profits to our customers
- Up-to-date computerized market reports
- The IDC "diamond banking" service, including the exclusive IDC Passbook Account to record your diamond acquisitions

Please contact one of our District Managers in your area to learn more about "diamond banking."

Armand Dion, Flint	313-232-4470
John Burns, Troy	313-588-7730
Richard Foster, Adrian	517-265-3530
Paul French, Three Rivers	616-273-9537
Roger Jones, Lansing	517-323-7314
Dan Junttila, Calumet	906-337-4925
Arnie Peterson, Calumet	906-337-2344
Bernie Sementelli, Flint	313-232-6820
Fred Berkman, Bay City	517-893-9222
Ray McDermett, Traverse City	616-258-9614

MICHIGAN REGIONAL HEADQUARTERS
James A. Fannon, 2120 - 44th Street, S.E., Grand Rapids, MI 49508 616-455-4310

International Diamond Corporation

Michigan Blues' plan: an HMO in every major city

By Dwight Angell, special to Michigan Medicine

BCBSM
and
HMO
DOCTORS

Call it a Blues blitzkrieg.

The aggressive tactics by which Michigan Blue Cross-Blue Shield is taking over health maintenance organization (HMO) markets in Michigan will soon vault the health insurer to a position as the dominant HMO force in the state.

So far, the Blues have purchased two HMOs representing about 16 percent of all HMO enrollees in the state. A third Blues-sponsored HMO starting up soon should increase the health insurer's grasp of the market by next summer to over 20 percent. And that percentage is an extremely low projection. (There are 265,000 HMO enrollees in Michigan).

The Blues' battle plan is clear; an HMO in every major city in Michigan. And then some.

For example:

- The Blues have spent $7 million to purchase two established HMOs — Health Central in Lansing and Group Health Services in Saginaw;
- Another $3 million is slated for the Health Care Network, an HMO for the tri-county area of Detroit. HCN plans to be operating this August;
- The Blues came close to signing a deal with Family Health Plan of Kalamazoo earlier this year, but one local hospital refused to cooperate. Negotiations collapsed and FHP folded. The Blues will be back, though, says Bullen, "when the dust settles."
- In March, the Blues' board of directors authorized $10 million for further HMO acquisitions. For the company, it was a rare business move. It allows Blues' management to strike faster when starting up new HMOs, rather than waiting for specific board approval.
- By next summer, the Blues hope to have HMOs firmly entrenched in Flint and Grand Rapids;
- The Blues are seriously eyeing the markets of Ann Arbor, the Upper Peninsula, Kalamazoo and possible purchase of other HMOs in the Metro Detroit area.

Mixed reaction seen

Is this cause for celebration? From the Blues' vantage point, no doubt. But from others, the reaction is mixed. Some health care officials in Lansing are raising their eyebrows.

On one hand, they are pleased as punch. For years, they have hammered away at the Blues to initiate tough cost containment programs. In their opinion, HMOs are a partial solution.

On the other hand, the real possibility of total domination by the Blues, they say, will eliminate true health care competition; and it is competition that can lower costs.

HMOs are, of course, the so-called wunderkind of the health care industry; the God-sent answer to escalating costs. They are a prepaid alternative delivery system, advocates say, where the physician can practice preventive medicine, where premiums are less, where covered services are more than traditional health plans, where financial incentives to abuse services are eliminated, and where patients are kept from wasteful hospitalizations. State and federal governments alike revised their regulations and offered easily-available financing to get HMOs on their feet.

But for each HMO success story, there is a countering horror story of an HMO run amuck. The reasons for collapsed HMOs are as varied as HMO types and models.

Michigan, to be sure, has its share of dismal tales:

- Health Central almost closed its doors two years ago this summer primarily because of naive administration and (ironically) too many enrollees too fast;
- Michigan HMO Plans in Detroit replaced its top two officials amid charges of poor handling of the ledgers;
- Family Health Plan in Kalamazoo lacked capital, among its many problems, and closed this spring.

So, as the wounded lie dying, BCBSM President John McCabe's troops are charging ahead with speed and acumen unknown for a business organization usually associated with caution and turtle-like maneuvers.

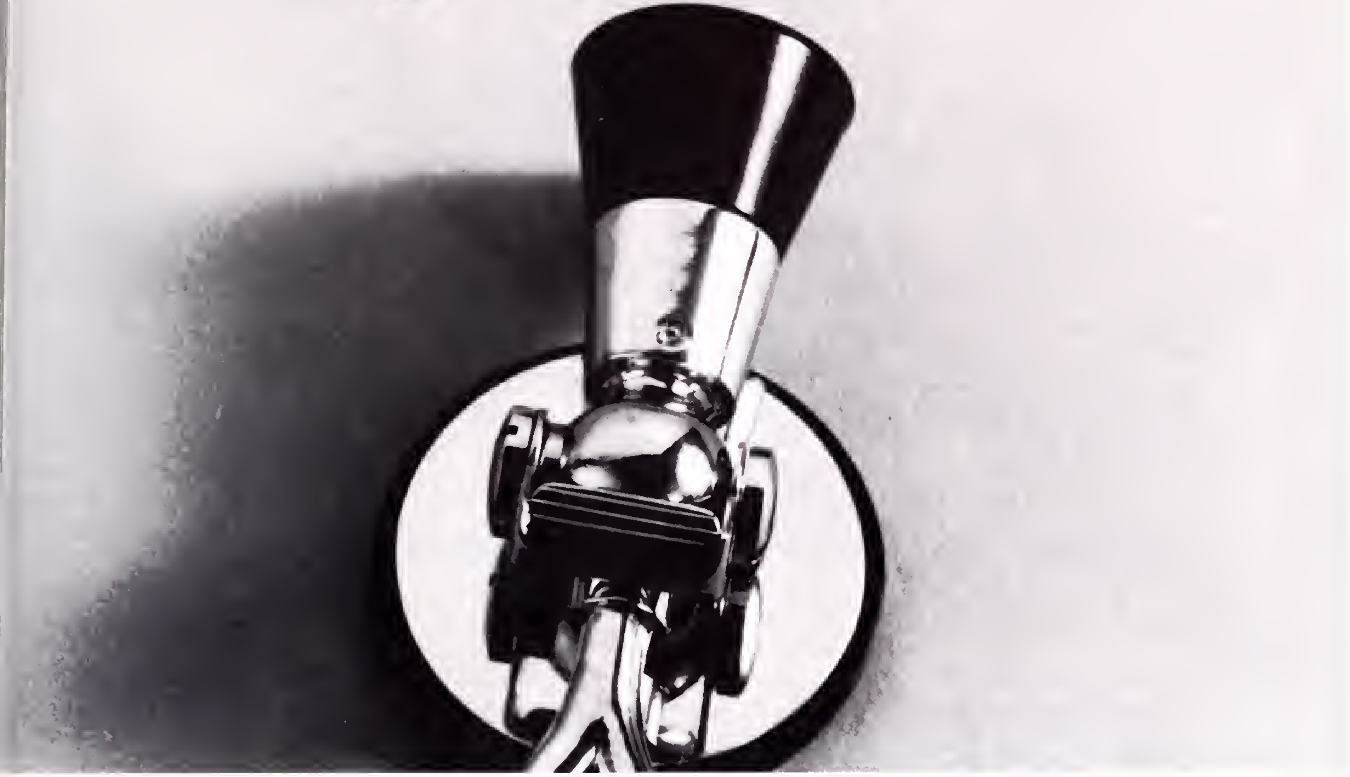
Why Blues interest?

So why are the Blues suddenly so interested in acquiring HMOs? In one sense, the cause is historical.

In the early 1970's the Blues had an HMO, but state law took it out of

continued on page 422

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN



Healthy Competition
Makes A Healthier Market

**Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.**

Occurrence Coverage

Choice of limits— $100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

their hands. (It is now called Health Alliance Plan, and is a non-profit, federally-qualified, group association HMO in metropolitan Detroit.)

And there are lost subscribers. The Blues, like the rest of Michigan, have been directly affected by the auto industry's depression and the subsequent lay-offs, which meant fewer subscribers. At present, the Blues have about 5.1 million subscribers, down from 5.3 million one year ago.

Other reasons, said Thomas Bullen in a recent interview, are 1) to offer new and old subscribers an alternative choice for health care and 2) "the cost containment of HMOs looks very promising."

Bullen is vice-president of financial services for the Blues and executive director of Health Central.

Getting into the HMO market, though, said Bullen, is not an acknowledgement that HMOs are "better" than fee-for-service plans.

"The jury is still out on which is a better system. There is no definite answer yet."

Bullen compares the unique position of the Blues — offering subscribers two vastly different choices — to the auto industry, where a company offers a wide selection of cars.

Why physician concern?

If physicians have any concerns about the Blues' rapid deployment into the HMO market, Tom Bullen doesn't understand why.

"Doctors should welcome the movement; to have the ability to control the health care dollar. Doctors don't want regulations and government bureaucrats telling them how each dollar should be spent or how to do this or that. HMOs represent a tremendous opportunity for physicians to solve the cost containment problem in Michigan and the country."

As the Blues plan to invade the entire state, they also plan to invade surrounding areas of their already established HMOs.

Health Central is a staff model, with a central location, with salaried providers. But the Blues are discussing with physician groups in two suburbs of Lansing the implementation of satellite clinics. The physicians in these clinics would be considered part of an independent practice association (IPA) model. The idea, of course, is to expand the HMO service area and thereby increase enrollment.

Saginaw's Group Health Service will eventually act as a springboard to nearby cities of Midland and Bay City, where the HMO will contract groups of physicians in each city.

At the same time, the Blues attempt to gear the type of HMO to the needs of each city. For example, the Blues plan a staff model in Flint and an IPA in Grand Rapids.

In the Detroit area, the Health Care Network is a mixed model — a combination of IPA and group arrangements that will comprise a network for providing care to the subscribers. (HCN was announced two years ago as the Primary Care Network, but the Blues had regulatory squabbles with the insurance bureau, thereby stalling the project.)

When the doors open this summer, HCN will consist of 275 primary care physicians split in 19 groups numbering from eight to 100 physicians each.

Each group has the four primary care services represented: pediatrics, family practice, internal medicine and obstetrics and gynecology. Physicians will continue to maintain their regular patient load, adding on HCN patients. The groups don't practice under one roof, but are loosely grouped together according to geographic proximity.

The network, said its executive director Thomas Beyersdorf, is "physician-driven."

Each group is totally independent. Each group is responsible to itself — in profits and in losses, in utilization and in quality assurance. Each group has total management control of itself and of each physician in the group. The Blues play only an administrative role.

"We don't mandate groups as to what to do. Financial incentives will take care of it," says Beyersdorf.

The Blues project a 15,000 member enrollment by next summer for Health Care Network, 50,000 in five years and hopefully 100,000 in a decade.

Funding the key

Today, HMOs in Michigan are faced with a two-edged sword wielded by the federal government. On one hand, President Reagan's theory of deregulation will filter down to HMOs, eventually allowing HMOs greater flexibility in order to entice more subscribers.

On the other hand, one can't expand unless one has money. And everybody interviewed for this article agreed that federal funds needed by HMOs either to increase their enrollment or to just sustain present operations, is about to dry up.

Ellis Bonner, head of both Comprehensive Health Services of Detroit and the Association of HMOs in Michigan, says the federal government isn't interested in further support of HMOs that have failed to pull their own weight.

Enter the Blues.

They represent the prime example of Reagan's economic policies: decrease federal help and intervention and increase private business capital and initiative. The Blues possess what HMOs only dream about — plenty of capital, a highly visible name and a resourceful managerial staff.

Of the two established HMOs the Blues have purchased so far, one needed capital to survive and one needed capital to expand.

Health Central would be an obit if the Blues hadn't taken it over. BCBSM has spent, said Bullen, about $5 million so far, but is finally operating Health Central in the black. Enrollment stands at about 23,000.

Saginaw's Group Health Services was in good financial shape, but lacked capital for further expansion. The Blues came up with $2 million this June, thereby lassoing another 20,000 persons into the Blues' subscriber roll.

The latter is a good example of the problem facing HMOs today, says Bullen.

"Where is the money going to come from . . . unless you have Blues' involvement? Otherwise, HMOs develop at a snail's pace and lose potential cost containment."

Monopoly rumors

It is the monopoly angle that has set rumors flying in Lansing; rumors of Blues taking over this HMO or that HMO. One rumor had it that the

continued on page 453

I'M A PHYSICIAN,

NOT
A BILL COLLECTOR"

What do you do when a patient won't pay? Call on I.C. Systems, the approved collection service that is as professional as you are. While maintaining good will for you in the community, I.C. Systems clears up bad debts in an ethical, efficient and effective manner. Mail this coupon today to learn how...

The System
Works

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ____________________
Address ____________________
City ____________________
State ____________________ Zip ________
Signature ____________________

Michigan Blues developing regional cost committees

By Deborah Zannoth, MSMS staff

In December of 1979 the MSMS Council approved a statement of principles and recommendations regarding physician involvement with the economic aspects of the health care delivery system. The principles were as follows:

1. The Michigan State Medical Society and its individual members share with the public a concern for the proper distribution, delivery and utilization of health care.

2. The Michigan State Medical Society has an enduring commitment to the delivery of health care in the most cost-effective manner.

3. The Michigan State Medical Society believes that physicians have a moral and civic obligation to inform, advise, or assist third parties in deliberations concerning the quality of health care, its utilization and its cost.

Also in that same year the BCBSM Board of Directors created its Regional Cost Committees (RCCs) Program, based on the belief that the best way to effect a change in health care practices is to actively involve local leaders who provide, use and pay for the services.

BCBSM then began developing this program. In September, 1980, the Council approved staff support for MSMS members serving on the BCBSM Cost Containment Committees, according to the MSMS Councils' December '79 guidelines. The support was to be in the form of data requests and data analysis.

In order to implement the committees, 10 regions were defined in the state, loosely derived from the 15 Councilor Districts of MSMS. The boundaries were modified slightly for management purposes, as well as to reflect information on where patients were seeking medical care services.

Each committee is comprised of three consumer members, three physician members (two MDs and one DO) along with one independent member who is not a health care provider but is knowledgeable of the economics, financing and delivery of health care. The members represent themselves rather than any organized entity.

Currently there are four active committees. They reflect those regions having the highest payments per member and utilization per person with BCBSM coverage. These four committees are in:

Region I — Wayne County.

Region II — Oakland-Macomb County.

Region III — Lenawee, Livingston, Monroe and Washtenaw Counties.

Region VII — Genesee, Huron, Lapeer, St. Clair, Sanilac and Shiawassee Counties.

Those physicians involved include the following:

Region I — Thomas Batchelor, MD, Detroit and Ned Chalat, MD, Detroit.

Region II — Everette Gustafson, MD, Pontiac and Earl Moehn, MD, Mt. Clemens.

Region III — Lyle Elliott, MD, Ypsilanti and S. Newton Kelso, MD, Monroe.

Region VII — Robert J. Rathburn, MD, Flint and Daniel J. Wilhelm, MD, Port Huron.

The MSMS Bureau of Economics has been involved with the process since inception. With the recent addition of a staff assistant to aid the Bureau Chief, John A. Richards, MSMS will be able to cover the RCCs in more depth. The Bureau is currently contacting those physicians serving on the RCCs and obtaining their perceptions of the process to date.

In the future, staff intends to provide assistance in analyzing the data presented by BCBSM. Plans also are underway for those physician serving on the RCCs to meet with the MSMS Task Force on Medical Care Costs headed by R. Jack Chase, MD Grand Rapids. Information mos likely will be shared by the physician members of both committees and then with the MSMS membership.

According to an Information and Operations Guide for the RCCs, Blue Cross Blue Shield of Michigan payments per member for professiona services vary significantly from are to area throughout the state. Th RCCs were established to study th phenomenon, determine reasons fo the variations and, from knowledg gained, find ways to minimize th variations for those regions in whic expenditures were found to be highe than average.

Each RCC is responsible for reviewing the cost situation within it region and working with the Healt Care Cost Committee of the BCBSM Board of Directors in establishing regional cost targets. The Health Car Cost Committee will establish statewide cost target for total BCBSM payment per member.

The RCCs have been instructe as outlined in the guide, to identif utilization problems within the region, to determine their causes an if possible, to develop solutions These solutions then will be recommended to the Health Care Cos Committee for corrective actions t be taken by appropriate groups an individuals, as well as by BCBSM.

Even though established in 197 the RCCs did not actually get underway until the fall of 1980. The have been meeting in a regular fashion since that time.

Each RCC has been operating a its own pace, and Regions I, II, an III have focused on professional benefit categories. Areas for further deliberation have been based on thre factors:

1) The payout of the benefit.

2) The degree of utilization rat deviation from other regions.

3) The reliability and comparability of utilization/cost data.

Region VII has taken a slightl different approach, and is addressin the cost containment situation b focusing on:

1) Reimbursement policies.

2) Hospital utilization and costs.

3) Education.

PAIN AND TENSION...
Double fault for
weekend warriors
ACE THE ACHE
with

Equagesic®Ⓘⓥ

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease*

EQUAGESIC—Abbreviated Summary

*__INDICATIONS__: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g , alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g caffeine, Metrazol or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses, peripheral edema and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION Each Equagesic tablet contains 150 mg meprobamate 75 mg ethoheptazine citrate and 250 mg aspirin

Copyright © 1981, Wyeth Laboratories
All rights reserved

*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia PA 19101
TM

Down with pain
Step up to reliable relief

for mild to moderate pain

Wygesic® (IV)

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol tranquilizers sedative-hypnotics or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts as well as misuse of tranquilizers alcohol or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks e g driving a car or operating machinery Patients should be cautioned accordingly

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore propoxyphene should not be used in pregnant women unless in the judgement of the physician the potential benefits outweigh the possible hazards

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group

PRECAUTIONS: Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants including alcohol

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness sedation nausea and vomiting These seem more prominent in ambulatory than in nonambulatory patients some of these reactions may be alleviated if the patient lies down Other adverse reactions include constipation abdominal pain skin rashes light-headedness headache weakness euphoria dysphoria and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported

DRUG INTERACTIONS: Propoxyphene in combination with alcohol tranquilizers sedative-hypnotics and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume Cheyne-Stokes respiration, cyanosis) extreme somnolence progressing to stupor or coma pupillary constriction and circulatory collapse In addition to these characteristics which are reversed by narcotic antagonists such as naloxone there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported and apnea cardiac arrest and death have occurred

Symptoms of massive overdosage with acetaminophen may include nausea vomiting anorexia and abdominal pain beginning shortly after ingestion and lasting for 12 to 24 hours However early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms the patient may feel less ill however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity jaundice coagulation defects hypoglycemia encephalopathy coma and death may follow Renal failure due to tubular necrosis and myocardiopathy have also been reported

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists naloxone nalorphine and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered preferably I V simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions

Oxygen IV fluids vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine which may cause anorexia nausea vomiting and drowsiness Appropriate literature should be consulted for further information (JAMA 237 2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

Copyright © 1981, Wyeth Laboratories.
All rights reserved

Wyeth Laboratories
Philadelphia, PA 19101
TM

Put us to the test.

Send us a split specimen—at our expense—we'll prove our accuracy.

First, establish an account with us. It won't cost you anything. Then at your convenience, draw a specimen using accepted procedures. Divide it and submit it under two names. When you receive the results, and you're satisfied they're statistically parallel, call us. We'll credit your account. It's that simple.

What else can you expect?

Quick results. We have three strategically located labs to provide routine test results within 24 hours, tissue results within 48 hours. Plus STAT service on some procedures.

Pickup and mail service. In many areas, our trained couriers will pick up your specimens. Outside our wide service areas, we provide prepaid mailing containers.

Quick-scan highlighted reports. Our reports were designed by pathologists. Abnormals are highlighted, making them easy to spot.

Staff pathologists. Abnormals are reviewed daily by our full-time staff pathologists. Any significant abnormal is immediately retested at no charge and the confirmed results phoned to you. Of course, our pathologists are available for consultation at any time.

Serum retention program. To make it easier for both you and your patient, every serum specimen is frozen for one week after initial testing. If further testing is necessary, just call us.

Accuracy assistance. We can assist you in training your personnel in laboratory procedures and proper specimen handling. Proper collection, handling and submission at your end further ensures accuracy at ours.

We're CBC and we've got a lot more to offer you. Our service is comprehensive, convenient, fast, and most important . . . accurate. Take the time to take our test. It may be one of the best things you ever do for your patients. And we *can* prove it.

To put us to the test call:
1-800-632-0706.

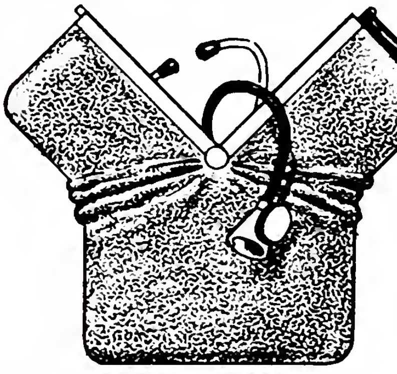
CBC CONTINENTAL
BIO-CLINICAL
LABORATORY SERVICE, INC.
Grand Rapids, Michigan • Toledo, Ohio
Mishawaka, Indiana

Better quality medicine at lowered costs by a cost effective laboratory service system (CELSS)

By Robert M. Nalbandian, MD, Grand Rapids
Raymond L. Henry, PhD, Detroit

This is the third in a series of articles by Michigan physicians responding to an MSMS request for medical cost containment ideas.

CO$T EFFECTIVE MEDICINE



Blue Pencil sketch

Doctor Nalbandian is professor of physiology, School of Medicine, Wayne State University, and chief, Hematology and Coagulation Services, Blodgett Memorial Medical Center, Grand Rapids. Doctor Henry is professor and acting chairman, Department of Physiology, School of Medicine, Wayne State University.

All physicians are aware that the annual cost of hospitalization and medical care of patients in the United States is increasing geometrically and apparently is beyond control. These costs are reaching a critical, intolerable figure. They also are triggering formation of a solid phalanx of critics, all demanding, in stentorian consensus, significantly lower medical costs. Able and honorably-motivated political leaders of the Congress are responding by legislative fiats and regulations.

Lower cost of medical care will follow; but at grievous costs. Inherent and inevitable in such reforms will be the destruction of that immeasurable but essential component which all physicians respect, "the quality of medicine."

The question arises then, "Is there an answer acceptable to physicians and patients alike to the paradox of enhanced medical care at lowered cost?" The welcome answer is, "There is."

The total annual cost of hospitalization is an incredibly complex result of scientific, moral, social, administrative, and organizational factors.

Prominent components of this huge sum are the domiciliary expenses of hospitalization and laboratory costs. Thus, if hospital stays could be shortened and laboratory test results made cost-effective, a significant reduction in annual hospitalization costs would be achieved . . . *without the sacrifice of the quality of medical care.*

An acceptable solution for such a paradox is the "CELSS" (Cost effective laboratory service system).

Figure 1 diagrams the basis by which these economies and benefits may be achieved. No batch or panel testing is involved. Rather, all laboratory studies are *customized and cued uniquely* to the medical or surgical problems of each patient. The CELSS concept exploits to the advantage of patients and the attending physicians three presently suboptimally-used informational sources from the laboratory: 1) The pathologist, 2) the medical technologist and 3) modern laboratory instrumentation.

The CELSS concept reorganizes the operational components and resources of the laboratory service so that the critical data base required by the physician for his diagnostic and therapeutic decisions is achieved in the shortest possible time.

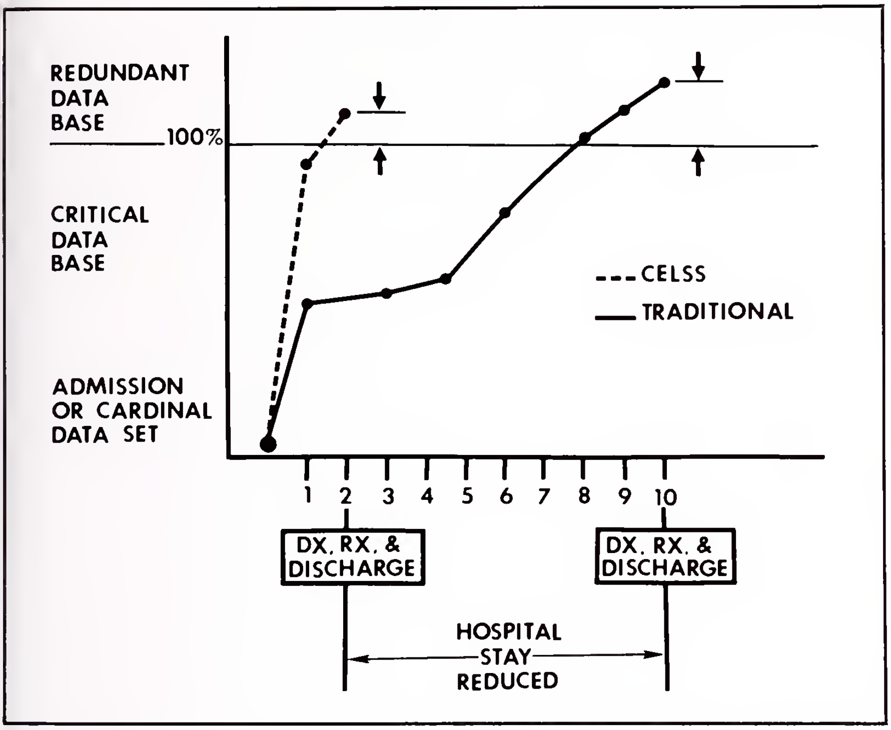
Furthermore, additional subsets of tests are done under algorithmic control, based on the initial (cardinal) set of tests ordered by the physician at the time of the patient's admission. Additional tests are undertaken only when an abnormal parameter is found among the cardinal set of tests.

Algorithm-guided additional tests are pursued immediately and automatically in the laboratory by the medical technologist and the pathologist without the usual pattern of step-wise, time-delayed ordering and reporting extending over several days. Thus, a complete set of germane and pertinent test data with little redundancy is rapidly presented to the attending physician for his decision and action. There is no intrusion on the prerogatives of the attending physician.

The economies afforded by CELSS stem from two sources: 1) reduced interval of hospital stay and 2) highly cost-effective sets of laboratory data with little or no redundance.

In larger medical centers, where substantial out-patient loads are attended, CELSS also may reduce operational costs and improve medical care.

The usual pattern of health care management for the "walking ill" pa-



This figure displays the crux of the CELSS principle. The critical data base (that minimum body of information on a hospitalized patient required by the clinician for diagnostic and therapeutic decisions) is acquired at an earlier time and with less redundancy with the CELSS system than by the traditional mode, as the purely illustrative curves suggest. Reduction in hospitalization costs arise principally from two sources: (1) shortened hospital stays, and (2) reduction in the redundancy of tests per patient.

tients is a tedious cycle of visits with incremental acquisitions of studies until sufficient laboratory data is finally in hand to make diagnostic and therapeutic decisions and/or hospitalization is effected. This process may take from several weeks to even a few months.

By the CELSS system, the critical data base could be completed and delivered to the attending physician with the patient's second out-patient visit. By triage, those patients requiring hospitalization would be selected with greater accuracy and admitted earlier, rather than later.

Other patients would be properly diagnosed and treated as out-patients. CELSS could clearly improve the operational efficiency and the quality of medical care offered to patients in the larger out-patient departments in this country.

In a recent published report, we discussed a benefit of CELSS we did not anticipate. Since a quarter of all medical malpractice claims against physicians arise from allegations of diagnostic error, the Medical Liability Advisory service stated, "Were the national CELSS protocol available and accepted as a standard testing procedure, a 'showing by a physician that he ordered such a procedure would be telling evidence in the defense of an inadequate testing case,' said a prominent malpractice attorney."

Finally, in life-threatening situations such as disseminated intravascular coagulation, or thrombotic thrombocytopenia purpura, complete diagnostic pertinent data could be on the chart within just a few hours of the time that specimens were drawn for the initial cardinal set of tests, since CELSS eliminates the traditional pattern of ordering indicated laboratory studies by stages and cycles and accelerates the process of customized patient-centered data acquisition.

In a CELSS laboratory operation, the pathologist's present role will have to change. The traditional role of the pathologist is that of a passive, technical, supportive, casual consultant. Under CELSS the pathologist's participation and contribution to data generation is dynamic, involved, online, with critical over-ride functions that additionally reduce laboratory tests, eliminate redundant tests, and thus enhance the pertinence of the data base offered to the clinician economically.

The CELSS is within the limits of present technological and professional capability. Because of the significant economies that can be achieved in medical care under the CELSS concept without compromising the quality of medical care, pilot controlled studies of the CELSS laboratory system deserve prompt implementation and statistical study.

Present systems of laboratory operation clearly are falling short of the current needs of patients and physicians alike. A change in the mode of clinical laboratory services is inevitable. Innovative laboratory operations which promise enhanced medical care at lowered costs compel our serious and immediate considerations.

(References are available from the authors.)

Primary prevention with high risk infants: Enhancing caregiver-infant interactions

By Samuel J. Meisels, EdD, Ann Arbor

Sketch from bulletin, "Infant Care," Children's Bureau Publication 8-1973, Office of Child Development, Office of Human Development, U.S. Department of Health, Education and Welfare (DHEW Publication 7 (OHD) 76-30015).

One of the major tasks of medicine, education, and the other helping professions is that of prevention. Prevention can take many forms, depending on its definition and implementation. The concept of primary prevention has been borrowed from the field of public health. It concerns actions taken to prevent the occurrence of disease or disability in large populations. In this paper, primary prevention is introduced as an agenda for neonatal intervention.

Primary prevention with high risk infants requires the identification of the precursors of serious developmental and physical disabilities as early in life as possible. This approach entails the establishment of appropriate treatment programs, and the coordination of a wide range of medical, social and educational services.

The task of identifying the precursors of potential developmental and medical problems has proven extremely elusive for the population of high risk infants. In the 1950s and 1960s Lilienfeld and Parkhurst and Pasamanick and Knoblock combined the complete range of deviant pregnancy outcomes under the expression "continuum of reproductive casualty." This expression was used to explain the relationship of abnormal antecedent events or conditions to developmental outcomes. That is, the reproductive risk continuum was proposed as a means of revealing a supposed chain of efficient casualty leading from early problems to later disabilities.

A major problem with the research that culminated in the continuum of biological risk is that it was based on retrospective rather than prospective methodology. In a retrospective approach, only those subjects who have a particular disorder are studied. Thus, retrospective studies are burdened by an overwhelming problem of selection bias. In contrast, prospective studies assume that the early risk factors have the status of independent variables; the later outcomes are the dependent variables (Sameroff and Chandler, 1975).

Extensive prospective studies have now been completed. The results of these studies do not support the implication of the early risk factors in the etiology of later disorders. One of the most comprehensive studies is known as the Collaborative Perinatal Project. This national project studied the relationship between 169 prenatal and postnatal variables and the overall development of more than 53,000 children. Broman, Nichols and Kennedy (1975) reviewed the intellectual performance at age four of 26,760 children whose mothers enrolled during pregnancy in the Collaborative Perinatal Project. Their findings were that social class variables had a much greater effect on intellectual development than did the presence of perinatal complications. Moreover, they determined that "prior to birth the most consistent predictor of intellectual retardation at four years of age was years of education completed by the mother" (Broman, Nichols and Kennedy, 1975, p. 228).

In another major longitudinal study, Werner, Bierman and French (1971) studied all of the children who were born and raised on the Hawaiian island of Kauai. They concluded that the family, social and environmental conditions were of greater influence on developmental outcomes than any but the most severe perinatal and neonatal abnormalities.

Thus, for children who are biologically vulnerable, the most po-

continued on page 432

Doctor Meisels is program director for special education, Institute for Study of Mental Retardation and Related Disabilities, The University of Michigan. He also is associate professor and chairman of special education at the U-M.

YOUR INCOME
Employees' Salaries
OFFICE RENT
Utilities

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3 . . . 1 out of 5 could be disabled up to 2 years . . . 1 out of 7 could be disabled up to 5 years.*

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc. Check these features of the Professional Overhead Expense plan sponsored by the MSMS.

- ☑ Up to $3,000 monthly benefit
- ☑ Waiver of Premium
- ☑ Survivors' Benefits
- ☑ Professional liability premiums are a covered expense
- ☑ Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more

"we're here to help"

Stratton – Cheeseman & Associates, Inc.
1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823
Call Toll Free: **800-292-1966**

*1979. The National Underwriter Company

tent single predictive variable appears to be the characteristics of the family and the caretaking environment. In recognition of the role that reproductive risk factors may play in predetermining an initial negative caretaking environment, Sameroff and Chandler (1975) proposed the phrase "continuum of caretaking casualty." In this transactional model, the child and his caretaking environment tend to mutually alter one another. To the extent that the child elicits and is provided with nurturance from his environment, positive outcomes are a likely consequence. To the extent that the child elicits and/or receives negative responses from the environment, the child is likely to be at high risk for later difficulties. In Sameroff's terms, "although reproductive casualties may play an initiating role in the production of later problems, it is the caretaking environment that will determine the ultimate outcome" (Sameroff, 1975, p. 274).

With the exception of gross insults that lead to serious brain damage, perinatal disorders are not consistently related to later childhood disorders. It is the quality of the subsequent transactions that take place between the child and his or her caretaking environment which serve to create or to reduce the linkage between earlier trauma and later disability. This transactional model will be explored more fully in the succeeding sections of this paper.

Project Welcome: A Program of Primary Prevention

The surviving preterm baby today is a product of cultural evolution and of medical technology. However, all too often, in the midst of the emergency medical atmosphere and the essential tubes and wires of the intensive care monitoring devices, the baby as an interactive, social being is lost. Richards (1979) notes that the baby is lost to him or herself because one of the first steps in becoming a social self depends on the association in time between the expression of changing needs and their satisfaction by a caretaker. For caretakers — be they nurses, parents or other caregivers — to be able to satisfy an infant's needs, the caretakers must become aware of the baby's specific, individual patterns in such a way that they can regulate and modulate their behavior in conformity with the infant's behavior and current state of development.

A program designed to focus on the needs of both the high risk infant and the caregiver has just been started in Boston, Massachusetts. Project Welcome is a federally funded (Office of Special Education, Handicapped Children's Early Education Program) project designed, in part, to elicit and encourage infant-caregiver interaction. The project is located at the Neonatal Intensive Care Unit (NICU) of the Children's Hospital Medical Center, Boston. It is a three-year project conducted jointly by Children's Hospital and Wheelock College that became operational in the fall of 1980. As such, no outcome data regarding the effectiveness of the project are available yet.

The project was created in order to respond to service and research needs that extend well beyond the particular boundaries of any given city or state. The project is designed to demonstrate a coordinated hospital/community model program for delivery of continuous service to infants who are born weighing 1250 grams or less.

Project goals. Three major project goals have been identified. The first goal is to increase the capacities of parents to meet the special needs of their high risk infant by providing the parents with practical assistance, information, and emotional support from professionals and from other parents during and after the baby's hospitalization. This is achieved through a family support program that includes a needs assessment, social services, a parent-to-parent program, an extended contact program, and parent education classes.

The second goal is to develop and implement a transition program for high risk infants which links their family, the NICU, community hospital and community agencies into a coordinated system of continuous service. This goal is achieved by implementing a nursery-based developmental intervention program, coordinated discharge planning, continuous family support through a Family Contact person from the project, and referral systems designed by the project in collaboration with existing service providers.

The third goal is to increase the knowledge of health care providers about the developmental needs of high risk infants and the existing services for these infants and their families and the knowledge of early intervention providers about the medical needs and services for these children. This goal is achieved by an outreach/liaison program that involves information, dissemination, referral consultation, and continuing education for health care professionals. In addition, a liaison program between Children's Hospital and early intervention programs will be established.

Gaps in Services and Prevention. These goals were selected in order to address several significant gaps in services that exist in Massachusetts as well as in many other states. For example, many NICUs maintain only minimal contact with the family and with the staff of community hospitals after the infant has been discharged home or to a community hospital. This lack of continued support for families and for community hospitals from specialists in the care of high risk infants is the first gap in service addressed by this project.

Second, the staffs of many NICUs and community hospitals are not specifically trained to assess and provide for the early developmental needs of long-term hospitalized high risk infants. Infants born at less than 1250 grams average more than two and a half months stay in a hospital after birth. Providing developmental training for parents and medical staffs as well as appropriate developmental intervention for high risk infants is the second gap in service that is filled by the project.

Finally, follow-up support in the home and case coordination after hospitalization are the third and fourth gaps that a project of this type can bridge. The community hospital, like the NICU, loses contact with the family and infant after discharge. It is possible that a community visiting nurse will be requested by one of the hospitals to visit the family during the first weeks at home. However, these nurses often do not have specialized training in pediatrics or child development since their primary responsibility in the community is usually care of the elderly. Early intervention programs for children birth through three are available in many communities. However, in most areas, there is no systematic way for these programs to obtain or receive referrals directly from the initial service providers — the community and tertiary hospitals. The family physician or pediatrician is the only person who might have an extended relationship with the family throughout this period. However, only a small percentage of referrals to early intervention services come from community physicians or pediatricians. Therefore, there is no guarantee that a family will be linked with an infant program through their doctor at a point when preventive services are still most likely to be optimally effective.

The concept of developmental intervention

The assumption of the project is that intervention early in life will enhance infant-caregiver interaction, thus contributing to more positive developmental outcomes for children as they grow older and preventing secondary and tertiary problems. The testing of this hypothesis lies at the heart of the research design for the project.

This quasi-experimental design focuses on changes in four areas or clusters of variables: infant development, infant-caregiver interaction, parent's perception of their infant, and maternal self-confidence. A control group will be followed for two years, in addition to the "treatment" group. A variety of measures and interview schedules has been selected or developed.

One of the major challenges facing this and every other early intervention project is to meaningfully define the term "intervention." A recent article in *Pediatrics* cautions that there are hazards associated with early intervention and claims that "Infant stim' and developmental therapy programs now represent a major industry in our country" (Ferry, 1981, p. 38). While both claims are exaggerated, it is important to carefully consider the appropriateness of the interventions utilized with high risk infants.

Als, Lester, Tronick and Brazelton (1981) note that in intervening we must seek to identify the current organization of each preterm infant in order to develop sensitive, and appropriate intervention plans. They caution that

> When one realizes the current organizational issues for the preterm infant, one becomes aware of the flaws and possible dangers of intervention programs which consider premature infants to be deficient full term infants and which, therefore, are intended to "train" infants in behavior appropriate for full term babies. (Als, et al., 1981 p. 17)

Indeed, an inspection of conventional "infant stim" curricula leads one to draw the analogy that premies are to infant-stimulation programs as preschoolers are to academically-oriented preschool programs. That is, in both cases the curricula are often not developmentally appropriate.

In the view of Project Welcome, developmental

continued on page 434

NME...

the "help you establish a successful practice" experts.

Our goal at National Medical Enterprises is to help you establish a comfortable and successful Primary Care practice.
Where you want it.
How you want it.
It's a goal we achieve by offering you a choice of over 60 well equipped acute care hospitals coast to coast, by offering you selected financial assistance, and by offering you management consulting when you begin your practice.
So whether you're interested in solo, partnership or a group practice, you should contact NME.
We're the experts!

For further information, contact:
Raymond C. Pruitt, Director, Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.

Toll-Free 800-421-7470
or collect (213) 479-5526.

NATIONAL MEDICAL ENTERPRISES, INC. NME

"The Total Health Care Company."
An Equal Opportunity Employer M/F

HIGH RISK INFANTS/*continued*
intervention and direct manipulation of the infant are not synonymous. An intervention can be an observation, a translation or an interpretation of infant and/or caregiver behavior. It can also be an appreciation of infant or caregiver strengths, abilities or vulnerabilities. Finally, it can also be a physical manipulation.

These interpretations of interventions are recorded on an Individual Developmental Plan that is prepared by the project for Primary Nurses and for families. The specific interventions derive largely from work based on the neonatal assessment scales of Brazelton and Als. Their work has led to a conceptualization of stages of early behavioral organization of preterm infants that follows the following pattern:

1. Stabilization and integration of physiological functions (respiration, heart rate, body temperature, digestion);
2. Increasing development of the motor system usually accompanied by an infringement on the balance of physiological systems;
3. Emergence of the full range of distinct states from sleep to awake to aroused;
4. Development and differentiation of the alert state to a more flexible, robust, accessible and reciprocal stage of environmental opportunity (Als, et al., 1981).

Thus, the premature infant can be conceptualized as moving from a physiological to an environmentally-oriented to an interactive stage of development. These stages can then be translated into appropriate interventions as follows:

"JOSEPHINE is 35 weeks of age, post-conceptional. She was born at 26 weeks gestational age with a birth weight of 750 grams. Her current weight is 840 grams.

"**Assessment:** J. is an infant with a low threshold for stimulation, especially during medical interventions and when she is in a supine position. However, she has a good capacity for alertness and sociability as seen in brief periods of alert state, locking onto the caregiver's face, and listening to her mother's voice. She brings her hands to her mouth intermittently, and only fusses when stressed. She is able to use external inhibitory aids to maintain state regulation, in particular by pressing her feet against the side of the incubator or by holding the caregiver's finger.

Interventions/Recommendations:

1. Begin and end all medical and developmental interventions by speaking softly to J. to alert and comfort her. Observe the heart rate monitor and note if heart rate increases or decreases while you are talking to her. At the end of the intervention use a phrase like, "it's all done now," to provide closure for her.
2. To assist J. in developing some stabilizing behaviors, let her grasp your finger and place a rolled blanket against the soles of her feet, especially when she is in the supine position. Give her tactile boundaries during all medical interventions. Monitor muscle tone and TNR on left side and, if asymmetrical, position J. more frequently on her right side.
3. When turning J. to a supine position, contain her legs and arms, and place her legs in flexion supported by a rolled blanket. Continue to allow her to hold your fingers during medical interventions.
4. After swabbing J.'s mouth with glycerine, allow her to suck on the swab and gently stroke her face and head while talking to her. Observe if there is a burst-pause pattern of sucking, and use the pause for social interaction.
5. End all interventions by talking with J. Place her in a side-lying position with supports at her back, stomach and feet, place her in a flexed position, head forward and shoulders rounded.

These interventions are implemented by the baby's primary nurse in the ICU, and are shared with the infant's parents. Each week a staff member from the project develops another set of interventions in consultation with the nursing staff. Additionally, parent support and parent-to-parent programs are taking place. As the infant moves through the special care spectrum to the Community Hospital and then to the home, the project maintains contact and support and provides access to medical, social and educational resources.

Summary. At this point, Project Welcome is still in its initial stages. It will be several years before the efficacy of the interventions implemented by the project can be effectively evaluated and the impact on its several target populations — parents, infants, medical staffs, early intervention programs — fully assessed. However, even at this incipient stage, the project can be appreciated in terms of its effort at translating into practice a theoretical idea of primary prevention and developmental intervention that is based on current research.

The noted psychologist, Jerome Bruner, has eloquently stated the importance of early childhood for the intellectual, social and emotional growth of human beings as probably "one of the most revolutionary discoveries of modern times" (Bruner, 1981, p. 9). By focusing on the unique characteristics of the preterm infant, and on ways in which these characteristics can be modified in order to positively influence infant-caregiver interaction, we may be able to enhance the developmental outcomes of these infants, thus ensuring, in Bruner's words, that "well begun is indeed half done."

(References are available from the author.)

Fact:

Alcoholism is a disease characterized by repeated,uncontrollabl drinking.

The important fact to remember is that alcoholism, when properly treated, can be arrested. Our primary goal at Insight is to help people understand and deal effectively with their alcoholism — through intensive, short-term therapy in a residential setting and a planned aftercare program involving families, employers, A.A. and other significant support groups.

For more information, call or write:

INSIGHT
AT
COLOMBIERE

9075 BIG LAKE ROAD, POST OFFICE BOX 258
CLARKSTON, MI 48016. TELEPHONE (313) 625-040

JCAH ACCREDITED
A PROGRAM OF
INSIGHT INC

Maternal Health Desk Reference Card No. 26

(Sponsored and prepared by the Committee on Maternal and Perinatal Health,
Michigan State Medical Society.)

HERPES SIMPLEX VIRAL INFECTIONS IN PREGNANCY

Herpes Simplex infections in pregnancy, especially during the latter weeks of pregnancy, can cause severe and occasionally lethal generalized infections in the newborn infant who is exposed to the Herpes virus during birth or during the neonatal period.

There are two types of Herpes Simplex virus. Type I involves primarily, but not exclusively, the mucous membranes of the mouth or lips and the skin above the waist. Type II is recoverable most often from lesions below the waist, on the skin or mucous membranes of the vulva, vagina, cervix, buttock and thigh.

While dependent somewhat upon the population group studied, the incidence of Herpes infections is especially high in the unmarried teenage group, and is estimated to be present in one percent of all pregnant patients. It is estimated that there is a 10 percent risk of neonatal infection if the maternal infection occurs prior to the 32nd week of pregnancy and a 40 percent to 50 percent risk if the infection is present in the mother at the time of vaginal delivery. For this reason it is important to attempt to avoid contact of the infant with the virus.

Infant exposure to the virus can occur in several ways. The most common way is by direct contact with the virus in the vagina or cervix during vaginal delivery. A second common route of exposure is an ascending infection that occurs after rupture of the membranes. A third potential route of infection, fortunately rare, is from intrauterine infection occurring during the viremic phase of a primary maternal infection. Still another source of exposure is infant contact with parents, family, or hospital personnel who may have active Herpes infections.

The Herpes virus is acquired by direct mucosal contact and has an incubation period averaging six to seven days. The initial or "primary" infection may be associated with a viremia causing mild fever and malaise or a severe disseminated infection including encephalitis, meningitis, or hepatitis. Chronic recurring or "secondary" infections are common and result from a reactivation of the quiescent virus in the nerve ganglion.

Herpetic lesions involving the mucous membranes of the mouth or lip are quite characteristic and easily recognized. However, 50 percent of the lesions may be asymptomatic if they involve the vagina or cervix, and for this reason vague vaginal discomfort or discharge should be investigated during pregnancy.

The diagnosis can be confirmed in two ways. The most reliable is isolation and identification of the virus by culture from the lesion. These cultures can be sent to the Department of Health Laboratories in Lansing or to several other viral labs in Michigan[4] if unavailable in a local hospital laboratory. The virus can often be identified more quickly by cytology preparations from aspirating the vesicles, or swabbing the ulcerated herpetic lesions. The typical multinucleated giant cells can be readily recognized with appropriate staining of these slides. Serologic testing has proved difficult and is unsatisfactory for purposes of diagnosis during pregnancy.

Treatment of local lesions is symptomatic only, but chemotherapeutic agents are available for treating systemic infections in the adult and in the newborn. Several phar-

---

This Reference Card was written for the Maternal Health Committee by J.R. Postle, MD, Petoskey, Michigan.

The information printed on this card is to be used as a guide and may not be applicable to all patients or under all circumstances. The advice and recommendations of your personal physician who understands your individual medical status best, should be respected.

maceutical companies have products currently being tested which show promise of being effective against the Herpes Virus, but none are available for public use as of this date. Treatment with liquid ether, scarlet red and other unproven remedies have been tried but are ineffective and may be dangerous.

When vaginal or vulvar Herpes lesions are seen or suspected during pregnancy, an accurate diagnosis should be established by viral culture and/or cytologic preparations, and follow-up culture of the cervix and vagina should be taken at several weekly intervals after 36 weeks gestation to determine the likelihood of the virus being present at the time of delivery. If the presence of the virus in the pelvic area is confirmed during the final weeks of gestation, a Cesarean delivery is recommended. An exception to this is when the membranes have been ruptured for four or more hours and there is presumption that an ascending type of infection has already occurred. The recommendation for Cesarean Section delivery includes both primary and secondary Herpes infection, if present in the maternal genital area at the time of the anticipated delivery.

After birth, appropriate sealing off of the lesions, hand washing, and gowning techniques may allow the baby to be with the mother who has an active lesion. Contact with relatives, friends or hospital personnel with Herpetic lesions should be avoided.

When perinatal Herpes infection or exposure of a newborn is suspected, consultation with a perinatal center is appropriate.

References: 1. *ACOG Technical Bulletin* #51, July, 1978. 2. *The Contemporary OB/GYN*, August, 1980. Marvin S. Amstey, M.D. 3. Hafez and Evans, *The Human Vagina*, Chapter 32. 4. The Michigan Department of Public Health, Bureau of Disease Control and Laboratory Services, Bertina Wentworth, Ph.D. 5. *The Medical Letter*, Volume 21, #4, February 23, 1979. 6. *JAMA*. Volume 243, #2, January 1, 1980, Kibrict.

UPJOHN MOTRIN

For the pain of osteoarthritis the proven power of

Motrin®

ibuprofen, Upjohn

600 mg Tablets

One tablet t.i.d.

Please see the following page for a brief summary of prescribing information.

Upjohn

1981 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

Motrin® Tablets (ibuprofen, Upjohn)

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other non-steroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: **Blurred and/or diminished vision**, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin*; use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels. *Coumarin:* bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship" (PCR)* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Caution: Federal law prohibits dispensing without prescription.

MED B-5-S

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

J-9042-4

July 1981

Ad Council
A Public Service of This Magazine
& The Advertising Council

MEDICAL NEWSFRONTS

High blood pressure is another potential health danger form absorbing too much PCB according to the June 26 *Journal of the American Medical Association.*

Scientists of the Centers for Disease Control have found rates of blood pressure for PCB study participants 30 percent higher than expected on the basis of national rates for a population of the same age, race and sex composition.

Polychlorinated biphenyls (PCBs) are complex chemical mixtures that were manufactured in the United States from 1929 until 1977, when the potential health hazards were confirmed. They were used in electric power equipment, inks, adhesives, pesticides and carbonless duplicating paper. PCBs are now widely found in the environment.

The chemical mix already has been known to cause liver cancer and reproductive problems in laboratory animals, and in humans has been blamed for skin disorders, liver problems and abnormalities in blood fats.

The only major dietary source of PCBs in the United States is fish.

Most fish contain levels well below the amount considered unsafe for humans, although freshwater fish from polluted waterways, such as the Hudson River or Lake Michigan, may have much higher levels, according to the CDC.

PCB levels in Lake Michigan in the years 1972 through 1974 were well above the safe levels for both trout and coho salmon.

This past influenza season in Michigan was characterized by outbreaks caused by two different influenza A strains, A/Bangkok (H_3N_2) and A/Brazil (H_1N_1), or strains considered to be slight variants of them. Although during the 1979-1980 season Michigan experienced both A/Brazil and B/Hong Kong strains, no isolates were positive for influenza B this past winter.

Of the 15 reported positive isolates for A/Bangkok, the first case had an onset of symptoms in late November and the largest number of positive isolates for A/Bangkok occurred during the week ending Jan. 9th. Of the 21 reported positive isolates for A/Brazil, the first case had an onset in late December and positive A/Brazil isolates peaked during the last week of January. Patients who were 24 years of age and older (where age was known) were positive only for A/Bangkok, and those under 24 years of age were positive for either A/Brazil or A/Bangkok.

Making accurate predictions about future influenza activity is difficult, but if the same strains are prevalent or the drifts are slight next year, it is not likely to be a severe season. The new vaccine being prepared by the manufacturers for the 1981-1982 season will share the same components as the vaccine administered this past season (A/Brazil, A/Bangkok, and B/Singapore), but the number of micrograms (mcg) hemagglutin (H A) per 0.5 dose will be increased from 7 mcgHA per part to 15 mcgHA per part. Recommendations concerning its use have not yet been determined.

— From the "Circular," Vol. 43, No. 10, May 11, 1981, Michigan Department of Public Health.

Revised hepatitis B information and interim guidelines are available from the Michigan Department of Mental Health for interested medical professionals.

The package of information also includes definitions of medical terms, medical information and articles on management of hepatitis-B surface antigen carriers in public situations.

The packet of information is designed for use in this time of "mainstreaming" the former mental patients of institutions. It is available by writing Frank M. Ochberg, MD, director, Michigan Department of Mental Health, Lewis Cass Building, Lansing, 48926.

DES (diethylstilbestrol) exposure and its possible consequences for mothers and their offspring born after 1940 are the subject of new pamphlets and brochures.

The pamphlet, designed for medical professionals' use, contains recommendations of research investigators in the DESAD Project of the National Cancer Institute. The project has studied DES-associated vaginal and cervical irregularities and the rare instances of clear-cell adenocarcinoma that occur in DES-exposed daughters, and other health effects.

The brochures are designed for public information. All are available by writing Vincent T. DeVita, Jr., MD, Director, National Cancer Institute, Bethesda, MD, 20205.

Bendectin — the popular drug that controls nausea in pregnancy — is given a clean bill of health as a possible cause of birth defects in two research reports in the June 12 *Journal of the American Medical Association.*

South Macomb Internists, P.C.
is pleased to announce
the establishment of
South Macomb Thyroidology
under the direction of
DAVID L. THOMSON, M.D.
(Diplomate ABIM-certified
Endocrinology and Metabolism)
Available Services Will Include:

PHYSICIAN ASSESSMENT
RADIONUCLIDE IMAGING
RADIOACTIVE IODINE THERAPY
THYROID FUNCTION TESTING

11012 E. 13 Mile Road
Warren, Michigan 48093
Telephone (313) 751-7171

MSMS Annual Scientific Meeting Nov. 17-19 planned to provide the best in CME

Breakouts into small group sessions like the one above at the 1980 MSMS Annual Scientific Meeting help assure that participants can learn what they need to improve their care of patients at home.

The MSMS Annual Scientific Meeting is carefully planned to assure the finest continuing medical education available to Michigan physicians.

Courses scheduled for this year's three-day event Nov. 17-18-19 at the Hyatt Regency Dearborn had to meet stringent requirements and undergo careful scrutiny before being approved as Category I material.

Let's take an example.

"Problems in Contemporary Pediatrics" will be offered from 1:30 to 5 p.m. Tuesday, Nov. 17. Course director is Robert C. Kelsch, MD, professor of pediatrics and communicable diseases, Department of Pediatrics at the University of Michigan Medical Center. His department is sponsoring the course.

The process

The course had its genesis in a letter sent routinely from the MSMS Annual Scientific Meeting Task Force to all Michigan medical schools and specialty societies. The letter announced it was time to begin planning courses and asked for suggestions from department heads and specialty society presidents.

Doctor Kelsch replied that he was interested.

Task force members wrote back saying they would like him to plan a course and suggested guidelines to be followed in its organization.

Doctor Kelsch then suggested a course emphasizing asthma drug therapy in children, stress testing to find cardiovascular abnormalities in children, environmental contaminants in human breast milk, long-term management of children with fever-associated abnormalities and intermittent proteinuria in children.

As requested, he also suggested five speakers for his course.

"We had no trouble approving Doctor Kelsch's outline for a Category I course at the Annual Scientific Meeting," says Frank Cox, MD, Detroit, task force chairman.

"It was clear he had planned a program which addresses the needs of the practicing physician. It was well-organized and thought out."

If the task force cannot approve of a course as planned, it will suggest changes to the director. If the course director is not willing to modify the course to meet criteria, the task force simply will refuse to approve the course.

"We believe it is our responsibility to ensure our courses meet the most stringent requirements," reports Doctor Cox. "The MSMS Annual Scientific Meeting has an excellent reputation for the high quality of its courses, and we intend to maintain that reputation."

The goal

The number one requirement each course must meet is that it help practicing Michigan physicians improve their patients' care.

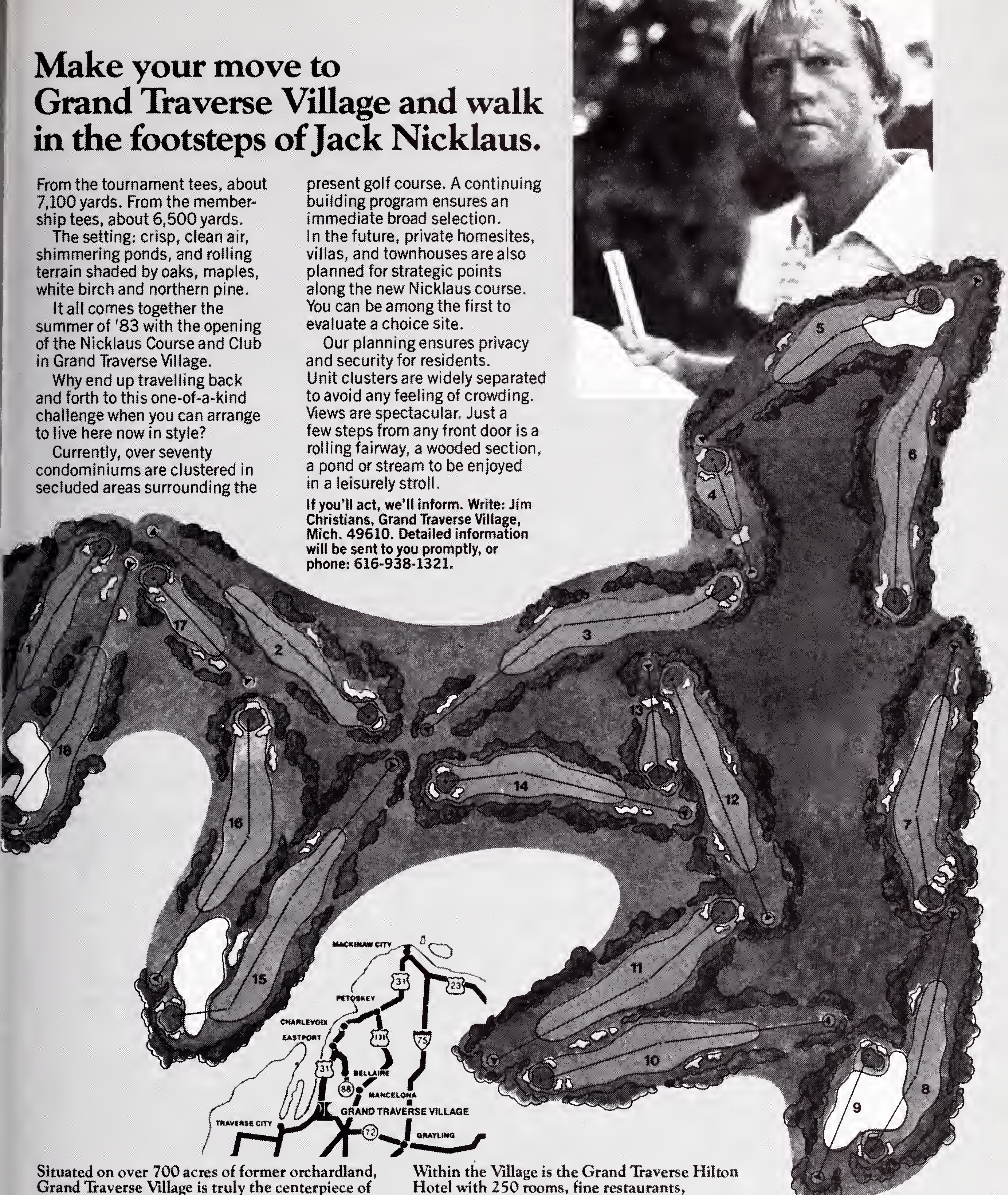
"We scrutinize every course proposal with this goal in mind," says Doctor Cox. "There can be lots of other reasons why a person might suggest a course for our program, but this is the one we insist they build their courses upon."

The Category I CME criteria for the Annual Scientific Meeting courses are based on those established by the AMA for its Physician's Recognition Award.

According to the PRA program, a CME activity, in order to meet the criteria for Category I, must be sponsored or co-sponsored by an organization accredited for CME. It also must comply with the definition of a planned program of CME.

A "planned program of CME" is defined as "one that covers a subject area in the scope and depth that is appropriate for the intended audience and that is planned, administered and evaluated in terms of educational objectives that define a level of knowledge or a specific performance skill to be attained."

In addition, every MSMS Annual Scientific Meeting to date has received approval from the American Academy of Family Physicians to award prescribed credits for continued certification in family practice.



Make your move to Grand Traverse Village and walk in the footsteps of Jack Nicklaus.

From the tournament tees, about 7,100 yards. From the membership tees, about 6,500 yards.

The setting: crisp, clean air, shimmering ponds, and rolling terrain shaded by oaks, maples, white birch and northern pine.

It all comes together the summer of '83 with the opening of the Nicklaus Course and Club in Grand Traverse Village.

Why end up travelling back and forth to this one-of-a-kind challenge when you can arrange to live here now in style?

Currently, over seventy condominiums are clustered in secluded areas surrounding the present golf course. A continuing building program ensures an immediate broad selection. In the future, private homesites, villas, and townhouses are also planned for strategic points along the new Nicklaus course. You can be among the first to evaluate a choice site.

Our planning ensures privacy and security for residents. Unit clusters are widely separated to avoid any feeling of crowding. Views are spectacular. Just a few steps from any front door is a rolling fairway, a wooded section, a pond or stream to be enjoyed in a leisurely stroll.

If you'll act, we'll inform. Write: Jim Christians, Grand Traverse Village, Mich. 49610. Detailed information will be sent to you promptly, or phone: 616-938-1321.

Situated on over 700 acres of former orchardland, Grand Traverse Village is truly the centerpiece of the northern Michigan resort area. It is a secured, self-contained living and recreational community, located just north of Traverse City, overlooking the east arm of beautiful Grand Traverse Bay.

Within the Village is the Grand Traverse Hilton Hotel with 250 rooms, fine restaurants, and sports complex embracing indoor tennis and racquetball courts, swimming pool, outdoor cross-country skiing, and an 18-hole Bill Newcomb-designed golf course.

GRAND TRAVERSE VILLAGE

GRAND TRAVERSE VILLAGE, Michigan 49610

CARE seeks physician volunteers

The international relief agency known as CARE is seeking Spanish-speaking board certified/eligible specialists who would be willing to volunteer a month to teach their specialty in developing countries.

Physicians are being sought for the following positions:

Dominican Republic — Santiago Regional University Hospital: Orthopedic Surgeon, Plastic Surgeon, Radiologist

Honduras — Escuela Hospital in Tegucigalpa: Internist, Endocrinologist, General Surgeon, Orthopedic Surgeon, Pediatric Orthopedic Surgeon, Perinatologist, Infectious Disease Specialist

Peru — Social Security Hospital in Lima: General Surgeon, Neurosurgeon, Obstetrician/Gynecologist, Orthopedist, Pediatrician, Pediatric Surgeon, Urologist, Ophthalmologist, Pathologist, Plastic Surgeon, Anesthesiologist, Dermatologist, Gastroenterologist, Abdominal Surgeon

If you think you would like to join such a humanitarian endeavor in the next two years, or have questions please contact Elizabeth Deslandes, Administrator, International Employment, CARE, 660 First Avenue, New York 10016, (212) 686-3110.

MCF studying self-curing leukemia

An experimental leukemia in animals that spontaneously reverses itself and disappears is being investigated by researchers at the Michigan Cancer Foundation, headquarters of the Comprehensive Cancer Center of Metropolitan Detroit.

"Cancer research has made its greatest gains against acute leukemia," says Marvin A. Rich, MD, Foundation Scientific Director. "In just the last few years, the use of accurate diagnostic tools and effective drug therapy has raised the five-year survival rates for leukemic children to beyond 50 percent. Many children with leukemia are being permanently cured today."

The self-curing leukemia is helping Foundation scientists unravel the key elements in the immunological processes which help the human body rid itself of cancer.

"Quality" United States & Canadian Decimals Since 1958

CARLTON
NUMISMATICS, INC.

• Professional Numismatic Counseling •
• Acquisition of Rare Coins •
• Portfolio Management •
• Investment Programs •
via
I.R.A., Keogh & Pension and Profit Sharing
Retirement Plans

To receive your complimentary copy of our Current Price List and Descriptive Brochures, please write or telephone:

Bingham Center • Suite 1646
30700 Telegraph Road
Birmingham, Michigan 48010
313 / 646-8846

BUSINESS HOURS:
Wednesday - Saturday 10:00 A.M. to 3:00 P.M. and by appointment.

Life Members A.N.A, C.N.A., M.S.N.S.: Associate Members C.A.N.D.

LOCUM TENENS

EMERGENCY MEDICAL POSITIONS

Emergency Consultants, Inc. has select opportunities in emergency medicine available on a locum tenens or full time basis. Positions in resort and recreational areas offer flexible scheduling, competitive hourly rates, and excellent benefits including malpractice insurance.

Emergency Consultants, Inc., a physician owned and operated corporation, currently services 60 hospitals in 12 states. Our organization accommodates professional and personal physician goals by providing a wide variety of locations with varying patient volume.

For further information contact: Emergency Consultants, Inc., Suite 115, 2240 South Airport Road, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
143 Courtland Avenue
Rockford, Michigan 49341
(616) 866-9395

ST. CLAIR AMBULATORY CARE CORPORATION

Detroit, Michigan

IS ACCEPTING APPLICATIONS FOR THE FOLLOWING POSITIONS IN A NEW AMBULATORY CARE CENTER IN THE NORTHEAST DETROIT SUBURB OF ST. CLAIR SHORES.

1. INTERNIST; GENERAL MEDICINE WITH OR WITHOUT SUBSPECIALTY
2. OBSTETRICIAN-GYNECOLOGIST
3. PEDIATRICIAN; GENERAL PEDIATRICS

THE NEW ST. CLAIR AMBULATORY CARE CENTER WILL BE A GROUP PRACTICE DEVOTED TO PRIMARY CARE, INITIALLY WITH TWO INTERNISTS, TWO OBSTETRICIANS, AND TWO PEDIATRICIANS WITH EXPANSION TO FOUR OF EACH AS INDICATED. COMPENSATION IS BASED PRIMARILY ON INCOME GENERATED WITH EXCELLENT FRINGE BENEFITS, AND A TWO YEAR INITIAL GUARANTEE.

APPLICANTS SHOULD BE BOARD CERTIFIED OR ELIGIBLE AND WILL NEED TO BE ACCEPTED FOR STAFF PRIVILEGES AT ST. JOHN HOSPITAL, AN AFFILIATE ALONG WITH ST. CLAIR AMBULATORY CARE CORPORATION, THE OXFORD INSTITUTE, AND THE ST. CLAIR RENAL CENTER, OF ST. CLAIR HEALTH SERVICES CORPORATION. APPLICANTS MAY APPLY IN CONFIDENCE TO:

ROBERT E. BIRK, M.D., F.A.C.P.
DIRECTOR, MEDICAL AFFAIRS
ST. CLAIR AMBULATORY CARE CORPORATION
22151 MOROSS ROAD
DETROIT, MICHIGAN 48236
(313) 343-3875

MEETINGS

MSMS, MSMS/A, AMA and medical assistants

Sept. 9 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Sept. 10-11 — AMA 41st Annual Congress on Occupational Health, Milwaukee, contact: Barbara S. Jansson, AMA, 535 N. Dearborn, Chicago, 60610, 312/751-6669.

Sept. 17-18 — American Medical Political Action Committee Political Education Conference, Washington, DC, contact: Diane Waltman, 202/857-1300 or write 1776 "K" St., N.W., Washington, DC, 20006.

Sept. 18-28 — MSMS/INTRAV Italian Adventure, contact: Marcelyn Ireland, MSMS Headquarters. 517/337-1351.

Sept. 18-19 — AMA Hospital Medical Staff Leadership Seminar, Drake Hotel, Chicago, contact: Department of Hospitals and Health Facilities, AMA, 535 N. Dearborn St., Chicago, 60610.

Oct. 21 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 21-22 — Fall Leadership Conference, MSMS Auxiliary, Lansing Hilton Inn, contact: Caroline Rich at MSMS headquarters.

Oct. 22 — Annual MSMS Public Affairs/Leadership Conference, Lansing Hilton Inn, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Nov. 3-4 — Diet & Exercise: Synergism in Health Maintenance, sponsored by the AMA, Walt Disney World Complex, Florida, contact: AMA Department of Foods and Nutrition, 535 N. Dearborn St., Chicago, 60610.

Nov. 4 — MSMS 1981 Health Issues Conference — Stress in the Contemporary Woman, Long's Convention Center, Lansing, contact: Sherry Wellman, MSMS headquarters.

Nov. 7-8 — Fall Seminar, State of Michigan Branch, American Association of Medical Assistants, Holiday Inn, Battle Creek, contact: Caroline Rich, MSMS headquarters.

Nov. 17-19 — 1981 MSMS Annual Scientific Meetings, Hyatt Regency, Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Other meetings:

Aug. 28-30 — Summer Meeting, Michigan Psychiatric Society, Holiday Inn, Traverse City, contact: Helen Schulte, MSMS headquarters.

Sept. 22-26 — American Medical Writers Association 41st Annual Conference, Prince Hotel, Toronto, contact: AMWA, 5272 River Rd., Suite 370, Bethesda, MD, 20016.

Oct. 1 — Michigan Psychiatric Society Council Meeting, Recess Club, Detroit, contact: Helen Schulte, MSMS headquarters.

Dec. 3 — Michigan Psychiatric Society Council Meeting, Recess Club, Detroit, contact: Helen Schulte, MSMS headquarters.

Dec. 5 — Eleventh Annual Workshop, Michigan Speech Pathologists in Clinical Practice (MSPCP), Detroit Athletic Club, contact: Christine Sowinski, Oakwood Hospital Audiology & Speech Pathology Dept., 18101 Oakwood Blvd., Dearborn, 48124, or 313/336-3000, ext 517.

Health planning, CON not cost containing, says ASIM

Attempting to pull together into one comprehensive report much of the hard data already collected from previous studies on health planning, the American Society of Internal Medicine (ASIM) has prepared "A Summary of the Data on the Impact of Health Planning on the Cost of and Access to Health Care," which is being distributed to opinion leaders nationwide.

The summary, which avoids anecdotal evidence usually cited by health planning proponents as well as opponents, points out that federally mandated health planning and certificate-of-need (CON) programs were designed to be cost-containment tools.

However, several studies of these programs present persuasive evidence, documented within the report, that mandatory health planning not only falls short of its goals, but, in many cases, is actually counterproductive to its stated objectives of bringing order, economy and efficiency to allocation of health-care resources.

Not only have recent studies indicated that a sizable portion of hospital costs can be attributed to government compliance with health planning and CON laws, the report says, but also, health planning has produced many "indirect costs," such as travel and legal expenses, as well as costs resulting from delay of treatment and construction of facilities.

Also, whether health planning regulations have accomplished their second major aim of "equal access to quality health care" is as much in doubt as the cost-effectiveness of the federal programs.

Calling for repeal of the 1974 Health Planning and Resource Development Act or elimination of federal funding, ASIM's report concludes that, based on existing hard evidence, "Health planning is most effective when allowed to respond to local conditions and specific needs. The combination of local political forces and the market forces in the economy are the most effective agents of health-care planning."

For a free copy of ASIM's "A Summary of the Data on the Impact of Health Planning on the Cost of and Access to Health Care," write or call ASIM at 2550 M St., NW, Washington, DC 20037, (202) 659-0330.

Naneva Hills

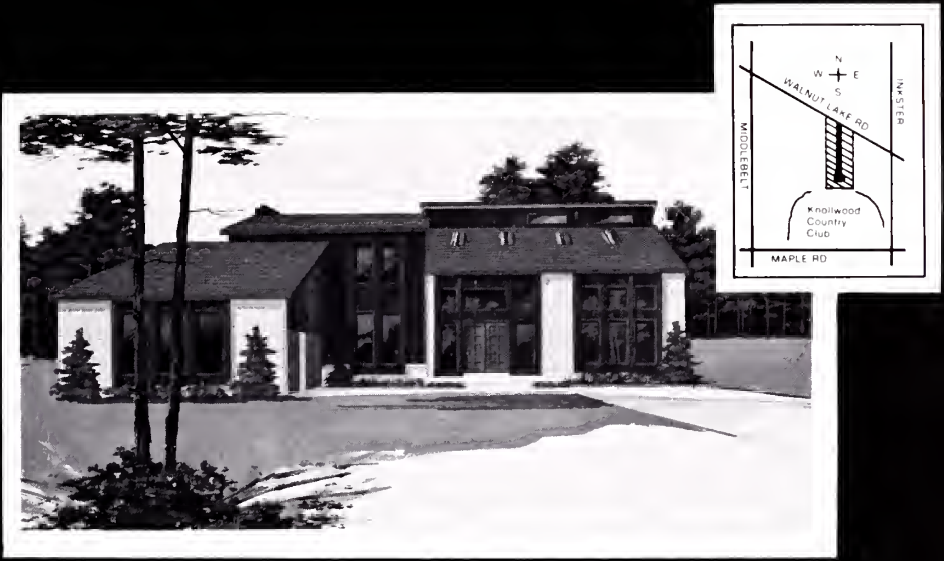
An artist creates only one original. A Calder. A Picasso.
A Matisse. In sculpture, in paint, in ink,
they work their individualized magic.

In beautiful West Bloomfield's Naneva Hills, Tambie Homes
has designed and created an exclusive number of
magnificent homes — each a Limited Edition.

Four dramatic homes on completely treed and landscaped lots
are ready for Summer and Fall occupancy. There are also 3 lots
remaining set against a beautiful ravine.

All the conveniences a discriminating buyer would expect
are included: studio ceilings, ultra-modern kitchen (with full
appliances like Jenn-Air and overstove microwave), Roman tubs,
private library, skylites, large deck, wet bar, 2½ or 3-car garage,
electronic air cleaner and much more. And there's still time
to add your own personal decor touches.

Or bring us your own plans and we will custom build your house
on yours or one of our lots. Determine your own price
with our unique owner participation plan.



Limited Edition

Naneva Sales Center
313/626-7466

5801 Naneva Court
S. of Walnut Lake Road, between Inkster & Middlebelt

Presented by
Tambie Homes
A Subsidiary of Knoll Enterprises, Inc.

U.S. ARMY MEDICAL CAREER OPPORTUNITIES

We are looking for physicians who want to be physicians. We offer a practice that's practically perfect, where you work without worrying whether the patient can pay, without endless insurance forms, malpractice premiums, and cash flow worries, and where you prescribe, not the least care, not the defensive, but the best. If that is what you want, join the physicians who have joined the Army. Write us or call collect for the following information. We can offer:

Specialty Assignments
Residencies
Fellowships
Internships
Health Professions Scholarships
Employment Opportunities

Captain Gerard Indrisano
AMEDD Procurement Office
Federal Bldg.
200 E. Liberty St.
Ann Arbor, Mi 48107
(313) 668-2190

CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Aug. 19-21, **Michigan Health Officers Association Annual Meeting. Location:** Park Place, Traverse City. **Sponsor:** Michigan Health Officers Association. **For:** All interested physicians and health officers. **Contact:** William W. Moon, MD, Box 43, Harrietta, 49638. **Approved for:** 5 hours of Category I Credit.

Date: Aug. 28-31, **Advances in the Management of Infectious Diseases. Location:** Grand Hotel, Mackinac Island. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical Center. **For:** All interested physicians. **Contact:** Janet Johnson, Office of CME, Towsley Center, U-M Medical Center, Ann Arbor, 48109, or call 313/764-2287. **Approved for:** 11 hours of Category I Credit.

Date: August 29-30, **Anatomy and Techniques of Regional Anesthesia. Location:** Gordon H. Scott Hall, Wayne State University, Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All interested physicians. **Cost:** $175. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 DRHUHC, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 9, **Lung Cancer: Current Diagnosis and Treatment. Location:** Kalamazoo Hilton Inn. **Sponsor:** Borgess and Bronson medical centers' Pulmonary and Oncology Units, and Southwestern Michigan Area Health Education Center. **For:** All interested physicians. **Cost:** $50. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 252 E. Lovell, Kalamazoo, 49007. (616) 383-6489. **Approved for:** 5 hours of Category I Credit.

Date: Sept. 9-10, **Western Michigan Trauma Symposium. Location:** Butterworth Hospital, Grand Rapids. **Sponsor:** Greater Grand Rapids Area American Association of Critical Care Nurses, and the Committee on Trauma, Michigan Chapter of the American College of Surgeons. **For:** All interested physicians. **Cost:** $80. **Contact:** Beth DeVriendt, Butterworth Hospital, 100 Michigan, N.E., Grand Rapids, 49503. 616/774-1405. **Approved for:** 10 hours of Category I Credit.

Date: Sept. 10-12, **Third Annual Conference on Interdisciplinary Team Care. Location:** Kalamazoo Hilton Inn. **Sponsor:** Center for Human Services, Western Michigan University, and Southwestern Michigan Area Health Education Center. **Cost:** $50. **Contact:** Clyde William, PhD, WSU Center for Human Services, Kalamazoo, 49007. (616) 383-4941. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 14-18, **Eighth Annual Family Practice Review. Location:** Gordon H. Scott Hall, Wayne State University, Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All interested family physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 DRHUHC, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 40 hours of Category I Credit.

Date: September 16, **"A Spore Catcher Looks at Mold Allergies." Location:** Sheraton Inn, Southfield. **Sponsor:** Michigan Allergy Society. **For:** All interested physicians. **Cost:** $17. **Contact:** Clyde R. Flory, MD, Secretary, Michigan Allergy Society, 600 S. Capitol, Lansing, 48933, (517) 371-1300. **Approved for:** 1 hour of Category I Credit.

Date: Sept. 16, **Renal Disease for the Clinician. Location:** Kalamazoo Hilton Inn. **Sponsor:** Michigan Nephrology Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Contact:** Charles L. Zeller, Jr., MD, Director/CME, SMAHEC, 252 E. Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 17-18, **Critical Clinical Issues in the Care of the Elderly. Location:** U-M Towsley Center, Ann Arbor. **Sponsor:** U-M Department of Post-graduate Medicine and Health Professions Education. **For:** All interested physicians. **Cost:** $120. **Contact:** Office of CME, Towsley Center, U-M, Ann Arbor, 48109. (313) 764-2287. **Approved for:** 13¼ hours of Category I Credit.

Date: Sept. 25-27, **Diagnostic Ultrasound. Location:** Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, and the University of Michigan Medical Center. **For:** All interested physicians. **Contact:** Robert P. Means, Ph.D., Towsley Center for CME, University Medical Center, Ann Arbor, 48109, or phone 313/763-1423. **Approved for:** 16 hours of Category I Credit.

Date: Sept. 28-30, **"Nurturing A New Beginning." Location:** Kalamazoo Center Hilton Inn. **Sponsor:** Division of Continuing Education, Western Michigan University, Kalamazoo. **For:** OB/GYNs, PEDs, Neonatalogists, FPs, and all others who are concerned about prenatal environment. **Cost:** $35, $65, $75 (for one, two and three days). **Contact:** Div. of Continuing Education, Western Michigan University, Kalamazoo 49008. **Approved for:** 21 hours of Category I Credit.

Date: September 30, **Advances in Pediatric Hematology-Oncology: Clinical and Laboratory Review. Location:** Room 2055, Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: October 3, **Immunochemical and Cellular Aspects of a B Cell Immunoproliferative Disorders. Location:** Room 2055 — Education & Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: **October 3-4, 9th Annual Burns Clinic Medical Meeting. Location:** Holiday Inn, Petoskey. **Sponsor:** Burns Clinical Medical Center. **For:** All interested physicians. **Cost:** $120. **Contact:** J.R. Postle, MD, Chairman, Burns Clinic Medical Center, P.C., Petoskey, 49770, (616) 384-4500. **Approved for:** 12 hours of Category I Credit, and 12 prescribed hours by the AAFP.

Date: Oct. 8-11, Regional Meeting, Michigan Chapter, American College of Physicians — Michigan Society of Internal Medicine. Location: Boyne Highlands, Harbor Springs. **Sponsor:** American College of Physicians and Michigan Society of Internal Medicine. **For:** All internists and primary care physicians. **Cost:** $30. **Contact:** Boy Frame, MD, FACP, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. **Approved for:** 21 hours of Category I Credit.

Date: Oct. 11-15, 1982, Abortion: Spontaneous and Induced. Location: Maui Surf Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1011. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-15, 1982, CDS: Contraceptive Delivery Systems. Location: Maui Marriott Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1101. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-16, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

Date: Oct. 15-17, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **For:** All interested physicians. **Cost:** $300. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, S.E., Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Oct. 28-30, Annual Review: Problems in Internal Medicine. Location: Room 2055, Education & Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Cost:** $200. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, (313) 876-1464. **Approved for:** 18 hours of Category I Credit.

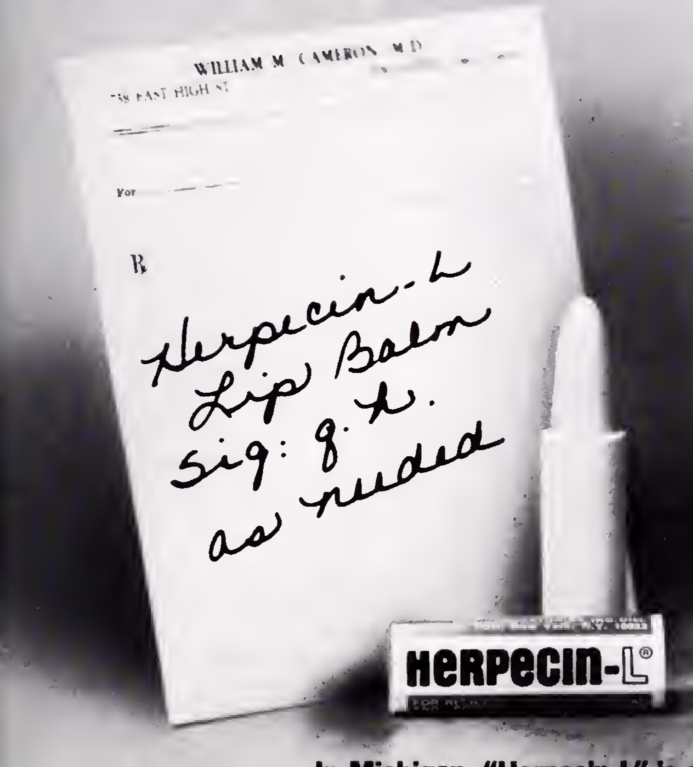
Date: Oct. 28-30, Blood Coagulation: Clinical and Laboratory Aspects. Location: U-M Towsley Center, Ann Arbor. **Sponsored by:** Medical schools of University of Michigan and Michigan State University. **For:** MDs with major interest in hemostasis. **Cost:** $215. **Contact:** Office of CME, Towsley Center, U-M, Ann Arbor, 48109. (313) 764-2287. **Approved for:** 20 hours of Category I Credit.

Date: Oct. 30-Nov. 1, Topics in Anesthesiology for the Eighties. Location: Grand Traverse Hilton Inn, Traverse City. **Sponsors:** Michigan Society of Anesthesiologists and University of Michigan School of Medicine. **For:** Anesthesiologists. **Contact:** Caroline Rich at MSMS headquarters. **Approved for:** 9 hours of Category I Credit.

Date: November 13-14, Twenty-Ninth Annual Symposium on Trauma. Location: Harper Hospital, Kresge Auditorium, Second Floor, 3990 John R., Detroit. **Sponsor:** Michigan Committee on Trauma of American College of Physicians. **Co-sponsor:** MI Chapter of American College of Emergency Physicians. **For:** Trauma specialists. **Cost:** $70. **Contact:** Charles E. Lucas, MD, (313) 494-3485. **Approved for:** 9 hours of Category I Credit.

Date: November 14, Symposium, "Working with Aggression." Location: Hyatt Regency Dearborn. **Sponsor:** The Michigan Psychoanalytic Society. **For:** All interested physicians. **Contact:** Jack Novick, PhD, Chairman, Program Committee, The Michigan Psychoanalytic Society, 16310 W. Twelve Mile Rd., Suite 204, Southfield, 48076. **Approved for:** 6 hours of Category I Credit.

Dx: recurrent herpes labialis



OTC.
See PDR for
Product Information.

For samples, write:
Campbell Laboratories Inc.
P.O. Box 812-M, FDR Sta.
New York, NY 10150

In Michigan, "Herpecin-L" is available at all *Arnold, Muir, Cunningham* and *Perry Drug Stores* and other select pharmacies.

New U-M Medical Center breakthrough may mean liver cancer cure in five years

Victims of liver cancer are surviving for years instead of several months when treated with a new drug delivery system pioneered at The University of Michigan Medical Center.

The system and its promising results on about 70 patients treated to date were described at a news conference July 9 by William D. Ensminger, MD, PhD, (see related article, page 398) associate professor of internal medicine and Burroughs Wellcome Scholar in Clinical Pharmacology.

The main feature of the system is an infusion pump, originally developed to infuse blood-thinning agents, that has been adapted in use by Doctor Ensminger for cancer therapy of tumors of the liver in which patients receiving standard cancer treatment often live only a matter of weeks.

More of the pumps have been implanted at The University of Michigan than anywhere else in the world. The treatment is given in University Hospital's Clinical Research Center, which is funded by the Division of Research Resources at the National Institutes of Health. Doctor Ensminger is associate director of the center.

The small infusion pump is surgically implanted in a pouch just under the skin of the abdomen. Surgeons insert a narrow tube leading from the pump into the hepatic artery, which supplies blood directly to the liver.

"The pump steadily releases anti-cancer drugs directly into the hepatic artery, which continuously exposes the tumor in the liver to very high — and hence more effective — concentrations of the drug," Doctor Ensminger reports.

Drug levels in the liver thus are 100 to 400 times greater than levels obtainable through conventional chemotherapy, such as intravenous infusion.

"In about 85 percent of the cases, tumors are significantly reduced. This method enables us to extend life expectancy from about four to six months to beyond two years," he said, noting that untreated cancer grows rapidly in the liver.

"Doctor John Niederhuber, head of surgical oncology at University Hospital, who has accurately placed the catheters and implanted the pumps, has been essential to the success of our program," Doctor Ensminger said.

He predicts that in five years the pump technique, coupled with radiation and other therapies, might represent a true "cure" for cancer confined to the liver.

In other medical developments:

Phenacetin, a drug contained in a wide range of pain killers including some brands of aspirin, empirin compounds and APC tablets (used as pain killers in the U.S. military forces), may be a hazard to humans.

Phenacetin was cited by the Michigan State Police Crime Laboratory as the tenth most frequently encountered drug in the Laboratory's most current toxicological studies.

"There is strong evidence that phenacetin may cause kidney and bladder tumors in humans," said Jimmie Vaught, a researcher in the Michigan Cancer Foundation's Carcinogenesis Department. "The drug, which was banned in non-prescription medications in Sweden and Australia, is still available over-the-counter in the United States and can be toxic to the kidney."

Medical studies in Sweden and Australia have attributed large numbers of kidney failure deaths and illnesses in those nations to the use of phenacetin.

A diagnostic x-ray process that promises to reduce radiation exposure and eliminate the need for x-ray film has been developed by scientists at The University of Texas M. D. Anderson Hospital and Tumor Institute.

The process also may eliminate the need for photographic film in many industries. Named the "Anderson System," the new process recently has had patent applications filed by The University of Texas System.

The heart of the system is a reusable plate that can take the place of film, including traditional x-ray film, in almost any photographic situation. A laser light beam and a computer complete the system. Together, they produce highly detailed pictures when the plate is electrically charged and exposed to light or x-rays.

"Not only should the system reduce the x-ray dose, but in some cases only one x-ray will need to be taken instead of a series," says Dr. Alfonso Zermeno, principal investigator on the project. "An x-ray taken with the system can be manipulated with the computer to produce much more information than a doctor can get from an x-ray film."

New help from an old friend.

CAMP®

Camp has been a friend and a familiar name to the medical community for more than 70 years. Now we are pleased to offer new help for your growing office needs. The kind of help that can actually improve the profitability of your practice.

Introducing CAMP COMP 1 . . .

a computerized financial information system that is simple to operate and surprisingly low in cost (less than $13,000). COMP 1 features a series of pre-written and tested programs that provide you with a better awareness of your practice activity and help you control your accounts receivable.

We've teamed up with Bell & Howell and Apple...

to bring you the most efficient computer system available today —a system completely supported by an on-sight maintenance program and continuing software updates.

Medical specialists helped create COMP 1

CAMP COMP 1 programs were developed by computer experts advised by a group of medical specialists. With COMP 1 you can quickly handle the time-consuming activities of receivable transactions, billing, insurance forms, update of patient financial records . . .and you'll maintain control over collections. COMP 1 will provide detailed financial information and a practice analysis for each doctor in the office.

Interested?

We'd like to tell you more about the CAMP COMP 1 system and how it can help you improve profits and simplify procedures. Return the coupon or call (517) 787-1600, ext. 217, for more information, including costs, program details and service agreement.

____ I am interested. Please send specifications.

____ My needs are immediate. Please call to arrange a demonstration.

Name ____

Address ____

City ____

State ____ Zip ____

Phone ____

Number of physicians in office ____

CAMP® COMP 1

Camp International, Inc.
P.O. Box 89, Jackson, MI 49204

MI-M

© 1981 Camp International Inc.

DEATHS

Loren G. Burt, MD
Alma

Loren G. Burt, MD, 59, of Alma, died May 8. He had been a life-long resident of Alma. He was a veteran of World War II and the Korean conflict, attaining the rank of captain. Doctor Burt had practiced medicine in Alma for 35 years.

Charles H. Ewing, MD
Grosse Pointe Park

Charles H. Ewing, MD, Grosse Pointe Park, died June 6 at the age of 80. An internist, he received his medical training at the University of Toronto. Doctor Ewing moved to Detroit and began practice in 1925, while also completing postgraduate work at the University of Michigan. He was a clinical instructor in medicine at Wayne State University.

Joseph J. LaHood, MD
Grosse Pointe Shores

Joseph J. LaHood, MD, 42, a resident of Grosse Pointe Shores, died May 24. He was the orthopedic staff surgeon for the Macomb County Easter Seal Society and was on the staff at St. Joseph East and West, South Macomb, Cottage and Bon Secours hospitals. He served as a surgeon with the First Medical Battalion, First Marine Division, in Vietnam and at the U.S. Naval Hospital in Long Beach, Calif. He graduated in 1963 from the Georgetown University School of Medicine. He served as a clinical instructor in orthopedic surgery at WSU.

AN ATTRACTIVE ALTERNATIVE TO PRIVATE PRACTICE — AIR FORCE MEDICINE

Did you go to medical school to become a doctor or an office manager, supply clerk, or repairman? If you want to concentrate on your medical practice and leave the administration to someone else, then Air Force medicine can be an attractive alternative to your private practice. You see, the Air Force uses a group practice system of health care. This system allows maximum contact between patient and physician with a minimum of administrative responsibilities. Nurses and technicians take care of the paperwork while you take care of the patients. You'll get to use the skills gained through years of education; to stay abreast of new methods and techniques; and, for qualified physicians, to specialize. These benefits, along with our excellent employment package, make Air Force medicine an attractive alternative to private practice. Find out how you can be a part of the Air Force health care team. We'll answer all your questions promptly and without obligation.

Contact 23400 Michigan Ave., Village Plaza, Dearborn (313) 561-7018; in Lansing (517) 372-3122.

AIR FORCE
A great way of life

Emad M. Shenouda, MD
Bloomfield Hills

Emad M. Shenouda, MD, 43, died June 22. He was an anesthesiologist at Henry Ford Hospital. Doctor Shenouda was a graduate of the University of Alexandria in Egypt.

Arthur E. Schiller, MD
Southfield

MSMS Past President Arthur E. Schiller, MD, Southfield, died June 11, at the age of 89. Doctor Schiller was a leading dermatologist in the Detroit area. He received his medical degree in 1914 from what is now the Wayne State University School of Medicine. He served on the staff of Receiving, Grace, Harper, Hutzel, Children's and Sinai hospitals. He was an associate professor of dermatology at Wayne State University. He was elected a fellow of the American College of Physiotherapy in 1927 and was an examiner for the American Board of Dermatology from 1953 to 1967. Doctor Schiller was chairman of the Dermatology Section of the American Medical Association and twice president of the Detroit Dermatological Society. He also led the Central States Dermatological Society.

Ralph T. Wills
Ft. Lauderdale

Ralph T. Wills, 76, former MSMS director of community relations, died May 15, in Fort Lauderdale, Fla. Mr. Wills moved to Florida 10 years ago following his retirement from MSMS. He was Michigan deputy secretary of state from 1952 to 1955. Prior to that, he worked in Washington, D.C. as deputy executive assistant to the postmaster general. Mr. Wills also served as secretary of the Michigan Republican Party for seven years. A graduate of the University of Michigan, he taught science at Flint Central High School.

Administrative office and main laboratory

AMRC the full service laboratory

- Complete range of individual tests and diagnostic profiles
- Medical consultation services
- Comprehensive quality control program
- Fully accredited
- Complete billing service

ADVANCE MEDICAL &
RESEARCH CENTER, INC.

1270 Doris Rd • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

ASSOCIATE CLINICAL DIRECTOR, Southwestern Michigan. Immediate opening for part-time psychiatrist to affiliate with progressive expanding, therapeutic community oriented, private-sector acute in-patient program at Holland Community Hospital, Holland, Michigan. Sufficient in-patient and out-patient private-insured patient referrals to immediately fill a full-time practice. Full complement of professional, team-oriented multidisciplinary staff offering a strong psychodynamic program already established. Unit is a model program in functional and interior design.

Located on the shores of Lake Michigan, this area is growing rapidly and affords excellent, year around recreational opportunities and is only 3 hours from Detroit or Chicago, one-half hour from Grand Rapids (metro area of over 500M). This psychiatric program is operated under a management contract between the hospital and Mental Health Management, Inc., (a nationally known psychiatric management firm) in Washington, DC. For further details contact: H. M. Voorheis, Vice President, MHM, Inc., 1010 Wisconsin Ave., NW — Suite 900, Washington, DC 20007.

GROUP HEALTH PLAN, a 24-year old, 140 physician, prepaid multi-specialty group with twelve clinics in the Minneapolis/Saint Paul area seeks board eligible or board certified associates in INTERNAL MEDICINE, ENDOCRINOLOGY, GASTROENTEROLOGY, OTOLARYNGOLOGY, OPHTHALMOLOGY, ORTHOPEDIC SURGERY, PEDIATRICS, and FAMILY PRACTICE. Positions available for 1981 and 1982. Send CV to: Paul Brat, MD, Group Health Plan, 2500 Como Avenue, Saint Paul, Minnesota 55108. An equal opportunity employer.

PLANT PHYSICIAN. Large industrial organization in Saginaw, Michigan, area has opening for medical doctor. Candidates should write to Box 18, Michigan State Medical Society, 120 W. Saginaw St., East Lansing, MI 48823.

DIRECTOR — FAMILY PRACTICE CENTER, FAMILY PRACTICE RESIDENCY PROGRAM: Holy Cross Hospital is looking for a physician to develop and direct a combined family practice service and education program in cooperation with the Department of Family Medicine, Wayne State University's School of Medicine. Candidates must be certified by the American Board of Family Practice with teaching and administrative experience in a family practice residency program. Salary will be competitive with private practice. A full spectrum of benefits will accompany this position, including a faculty appointment within the Department of Family Medicine, Wayne State University's School of Medicine. Please forward resume to: Bernardo M. Danan, MD, Chief of Medical Staff, Holy Cross Hospital, 4777 E. Outer Drive, Detroit, Michigan, 48234. An equal opportunity employer M/F.

POSITION NOW AVAILABLE in the Department of Internal Medicine for physician with subspecialty interest. 50 man multispecialty clinic in ideal location in Southern Wisconsin. Contact: R. E. Hassler, MD, The Monroe Clinic, Monroe, WI 53566, (608) 328-7000.

OPHTHALMOLOGIST WANTED to do office ophthalmology two or three days a week in well-equipped suburban office outside of Detroit. Excellent terms. Reply to Box 19, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

OPHTHALMOLOGIST FULL-TIME, outstanding opportunity to join busy practice in suburb of Detroit. Reply to Box 20, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

NEED FULL TIME OR PART TIME PHYSICIAN OR P.A. in a busy general practice in semi-rural set-up close to Ann Arbor. Some industrial and insurance physicals. Very interesting and varied. Salary negotiable and commensurate with experience. Please call 313-697-9300 or send resume to Belleville Medical Clinic, 265 Main Street, Belleville, MI 48111.

PHYSICIAN NEEDED for Jackson Medical Center, Inc., a non-profit clinic providing medical care for patients in need, regardless of ability to pay. A permanent position with very attractive salary (approximately $50,000.00), 30-40 hour work week, no weekends, no nights, no hospital duty. Prefer family physician. Contact: E. Willoughby, MD, 569 Wildwood Ave., Jackson, MI 49201.

PHYSICIANS NEEDED IN ROGERS CITY AND POSEN, MICHIGAN. Excellent opportunity for physicians seeking a wide variety of financially rewarding professional experiences. Located near Lake Huron with excellent outdoor and family lifestyle. Attractive income guarantee in solo or group practice settings. If interested, call collect to: Evans Calas, Assistant Administrator, Rogers City Hospital, (517) 734-2151.

CALIFORNIA-DIRECTOR POSITIONS AVAILABLE. Emergency medicine physicians needed for rural Northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit-sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610. 415/832-6400.

PART-TIME PHYSICIAN needed to do routine physicals to assess donor suitability for plasmapheresis. Good position for older physician looking to slow down. Malpractice coverage provided. Contact Thomas Anderson at American Plasma Management, Kalamazoo, MI. Phone 616/381-0086.

Positions with The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Positions wanted

MEDICAL LIBRARIAN with several years of experience in a hospital library and a malpractice law firm is now available to provide research for publications, seminars, courses, and legal cases. Uses resources of major universities' medical libraries. $20/hour. Contact at (313) 846-3420 or write to 4771 Ternes Street, Dearborn, MI 48126.

Miscellaneous

COMPHEALTH — Locum Tenens — Physicians covering physicians, nationwide, all specialties. We provide cost effective quality care. Call us day or night. T.C. Kolff, MD, President, CompHealth, 175 W. 200 S., Salt Lake City, Utah 84101 (801) 532-1200.

FOR SALE: Medical Clinic/Office Building (approximately 9,000 sq. ft.) directly across from Detroit's Mount Carmel Hospital and within three miles of six other hospitals. Contact Stephen Sell, Metropolitan Society for Crippled Children and Adults, 313-341-4900.

EXCELLENT ASSUMABLE MORTGAGE on this traditional pillared colonial with contemporary flair on a beautiful winding street of Twyckingham. Luxurious amenities. Two master bedroom suites, marble, parquet, alarm systems, stereo, sprinkling systems, quality landscaping and much more. $144,400. Desirable Southfield location. Esther Graff, (313) 559-8333 Aetna Realty Company.

HOME-OFFICE for sale, by owner, Mason, 12 miles south of Lansing. Growing area, good schools, commercial zoning. $72,000. (517) 676-5081.

HILTON HEAD ISLAND, SC, Sea Cabin new luxury resort condominium, near beach, next to lagoon, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, Jacuzzi whirlpool, canoeing, biking, and fishing, etc., weekly $360 call or write (313) 661-1150, 30390 Tanglewood, Farmington Hills, MI 48018.

DELUXE MEDICAL SUITE FOR LEASE IN RYAN DENTAL-MEDICAL CENTER LOCATION: Choice corner property of 17 Mile Rd., and Ryan Rd., Sterling Heights, MI. Located in exact center of approximately 4000 new homes in one mile radius. Suite size: (1) approximate 1,350 square feet; (2) 5 large windows for natural light; (3) front and rear entrance for doctor; (4) 38 car parking lot; (5) beautiful landscape. Will build to suit pediatrician(s) or family physician(s). Terms are negotiable. Call (313) 978-8233.

TUITION ASSISTANCE PROGRAM, INC. P.O. Box 6221, Duluth, MN 55806. Matching communities-seeking-physicians with physicians-in-training requiring tuition assistance. Keith Hummel, Director. Write for more info.

HOWELL, MICHIGAN — Two suites available in attractively designed medical-dental building. Complex conveniently located within walk-

ing distance of hospital which serves fastest growing county in the state. Unlimited opportunity for hardworking family practitioner looking to establish large practice. For information, call (517) 546-7630.

THE PERFECT RETREAT. Outstanding year round vacation home nestled in a secluded bay, in the midst of the North Woods of Michigan's upper peninsula. This custom designed home of rough sawn cedar has 12 ft. cathedral ceiling, 3 bedrooms, 2½ baths, 3 fireplaces, sauna and 50 ft. deck overlooking Portage Lakes' Torch Bay. The 100 ft. lakefront property includes adjacent guest house, with fireplace and deck, plus a 2 car garage. 15 minutes from Houghton-Hancock Jet Airport, downhill ski facilities and Lake Superior. Furnished if desired. Call (513) 871-7888 or 871-0632 or write R. Leonard Keppana, 3565 Bayard Dr., Cincinnati, OH 45208.

SNOWMASS/VAIL "MEP" SKI SEMINAR on Management Enrichment for the Health Professional. Ski Snowmass, Colorado the weeks of December 19, 1981 or March 20, 1982; or Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Trip expenses deductible for doctor and spouse. For information: M.E.P., An Education Corporation, 906 Cooper Avenue, Glenwood Springs, Colorado 81601; or 1-800-525-3402.

ON BEAUTIFUL AUSABLE RIVER (Main stream 195 ft. frontage, 3.6 acres). Prime trout fishing out your front door. Well insulated year around retreat. Wood stove plus brick fireplace. 4 bedrooms, two baths. Garage. 5 miles east of Grayling. $98,000 — Terms — #335 ask for Ruth. Century 21 River Country Grayling. (517) 348-5474 or (517) 348-9868.

HELICOPTER INVESTMENTS — We have available leases, sales, flight instruction, charter and a project consultant to assist you with your helicopter needs. Helicopters, Ltd., P.O. Box 667, 618 Silver Lake Rd., Linden, MI 48451. (313) 735-4121 or (313) 735-9018.

LUXURY CHALET FOR SALE, beautifully furnished, 5 large bedrooms, 3 full baths, in all-season northern Michigan resort. Golf, tennis, skiing, water sports, hunting, fishing, near excellent airport. Ideal for two-family or corporate ownership, too. Owner, (616) 587-9241 after May 25.

WE HAVE VARIOUS QUANTITIES OF MEDICAL EQUIPMENT available in excellent condition. We buy, sell, trade, move. New equipment also available. Call Doctor Medical Resale, (313) 569-4407, 9 a.m. to 9 p.m.

OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury, two & three bedroom units. Near Boyne ski hills. $92,000-$96,500. Furnished unit rentals available for vacation year round. A.K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

Blues/*continued*

Blues will have 60 percent of all HMO enrollees in their pocket by year's end. That is most unlikely.

Senator William Faust asked for an opinion by the Attorney General's office abou the Blues' involvement with HMOs. But the request was denied, as is the policy of Frank Kelley's office, when there is pending litigation. (That litigation is the Blues' challenge that the new BCBSM restructuring bill is unconstitutional. The only mention in the bill about Blues and HMOs is simply that Blues can have them. Period.

Neverthless, Dominic Dannunzio is concerned. He is assistant commissioner of the state insurance bureau. He is glad that the involvement of the Blues — with its money and expertise — will insure that HMOs will continue to exist in Michigan.

But for those same reasons, he sees that HMOs, other than those owned by the Blues, will not survive.

There will be no difference between the HMO market and the Blues. They will be one. The Blues will become the market. They will control the price. Competition will not exist, as the Blues will be competing against themselves. Healthy HMOs help change physicians' practices. But not when they are one and the same with the Blues."

Dannunzio, as do some others, sees the Blues' motivation for HMO involvement as a means for greater power. The Blues already have a lion's share of the traditional fee-for-service arena. And with the Blues' HMOs set up as wholly-owned, nonprofit, nondividend subsidiaries, the only thing the Blues gain, other than more subscribers, is more power.

Similar mixed sentiments were expressed by Harry Iwasko, an assistant attorney general, Commerce Division.

"The Blues' involvement should be good. It is a step towards cost containment. And Michigan, more than any other state in the country, needs cost containment."

Blues' competitive edge

But the Blues' potential monopoly also bothers Iwasko. He points to the hospital 'discount' that the Blues have enjoyed for decades. The Blues pay hospitals a lower rate than do commercial insurance companies and HMOs. The state-wide average is 16 percent lower.

This is a favorite complaint of HMO administrators who must pay hospitals the full charge. The 'discount' represents another competitive edge the Blues have over HMOs.

Iwasko: HMOs can't exist against the Blues. The Blues will probably dominate the HMO arena more than they do the fee-for-service.

"Are the Blues eliminating HMOs from competition or are they trying to bring about cost containment?"

"Five years from now, there will be a few weak HMOs versus the Blues, and a few weak commercial carriers versus the Blues."

Iwasko believes that the other provider left to create viable HMOs to compete successfully against the Blues is hospitals. He sees hospital-based HMOs as true cost containment entities.

Thanks to our advertisers

Advance Medical and Research Center	451
Blue Cross/Blue Shield	401
Brown Pharmaceutical	397
Burroughs Wellcome	409
Campbell Labs	447
Camp International	449
Carlton Numismatics	442
CBC Labs	427
Eli Lilly	411
Emergency Consultants	442
Grand Traverse Development	441
I. C. Systems	423
Insight at Colombiere	434
International Diamond Corp.	419
Medical Protective	443
Merrell-Dow	417
Merrell National	415, 416
Michigan Physicians Mutual	413
MSMS Annual Scientific Meeting	IFC
Naneva Hills	445
National Medical Enterprises	433
Pennwalt	403, 404, 405, 406
Physicians Insurance Company of Michigan	421
Pine Lake Forest	399
Roche Laboratories	390, 391, IBC, BC
South Macomb Thyroidology	439
St. Clair Ambulatory Care Corp	443
Stratton Cheeseman	431
Tri-City Community Mental Health	391
Troy Biologicals	412
University Microfilms	391
Upjohn Co.	437, 438
U.S. Air Force	450
U.S. Army	446
Wyeth Labs	425, 426

'Stress and the contemporary Woman' theme of MSMS conference Nov. 4

Doctor Shearer

Doctor Eliot

She's an equal opportunity victim of stroke, heart attack and ulcers.

Today's American woman must decide whether or not to bear children, whether to try for "superwoman" status and attempt to handle marriage, family and career all at once.

Then there are the issues of sexual discrimination and harassment, the special problems of the minority woman and the challenges to a woman without a life partner.

These are major stresses for women, and these conflicts influence her health and the medical care she seeks from her physicians.

MSMS conference

To help Michigan physicians cope with these problems, MSMS is presenting an important new conference, "Stress in the Contemporary Woman." The date set is Nov. 4 and the location is Long's Convention Center, Lansing.

Conference chairman is Marguerite Shearer, MD, Dexter, who is being assisted by Sherry N. Wellman and Ellen Vinocur Potash of the MSMS staff.

The conference will award Category I credit to physicians who attend. Enrollment will be limited to 200 persons. Registration information and forms will follow in future issues of *Michigan Medicine* and *Medigram*.

Conference sessions are planned on preventive and stress medicine, the critical decision points in life, the humorous side of stress in the contemporary woman's life, identification and management of stress, and reproductive issues and sexuality.

Keynote speaker will be Robert Salim Eliot, MD, chairman, Department of Preventive and Stress Medicine, University of Nebraska Medical Center.

Other speakers scheduled are Kathryn McAuliffe, MD, Lansing family physician; F. Paul Pearsall, PhD, chief, Problems of Daily Living Clinic, Sinai Hospital of Detroit; Susan E. Adelman, MD, Southfield surgeon, Editor, "Detroit Medical News," and secretary, Wayne County Medical Society; Linda J. Logsdon, MD, Southfield psychiatrist, and Marguerite R. Shearer, MD, and Marshall L. Shearer, MD, Ann Arbor-area husband and wife psychiatrist team.

Moderators will include Louis R. Zako, MD, Dearborn Heights family physician; Patricia Leuzzi, assistant director, Michigan Women's Commission; Thomas R. Berglund, MD, Portage family physician and chairman, MSMS Council, and Janice Gross, MPH, Office of Health and Medical Affairs, Lansing.

Keynote talk

Doctor Eliot's presentation will help physicians guide their patients to finding ways to be productive without being self-destructive. His approach is informative and entertaining and will relate directly to the everyday work and leisure activities of the contemporary woman.

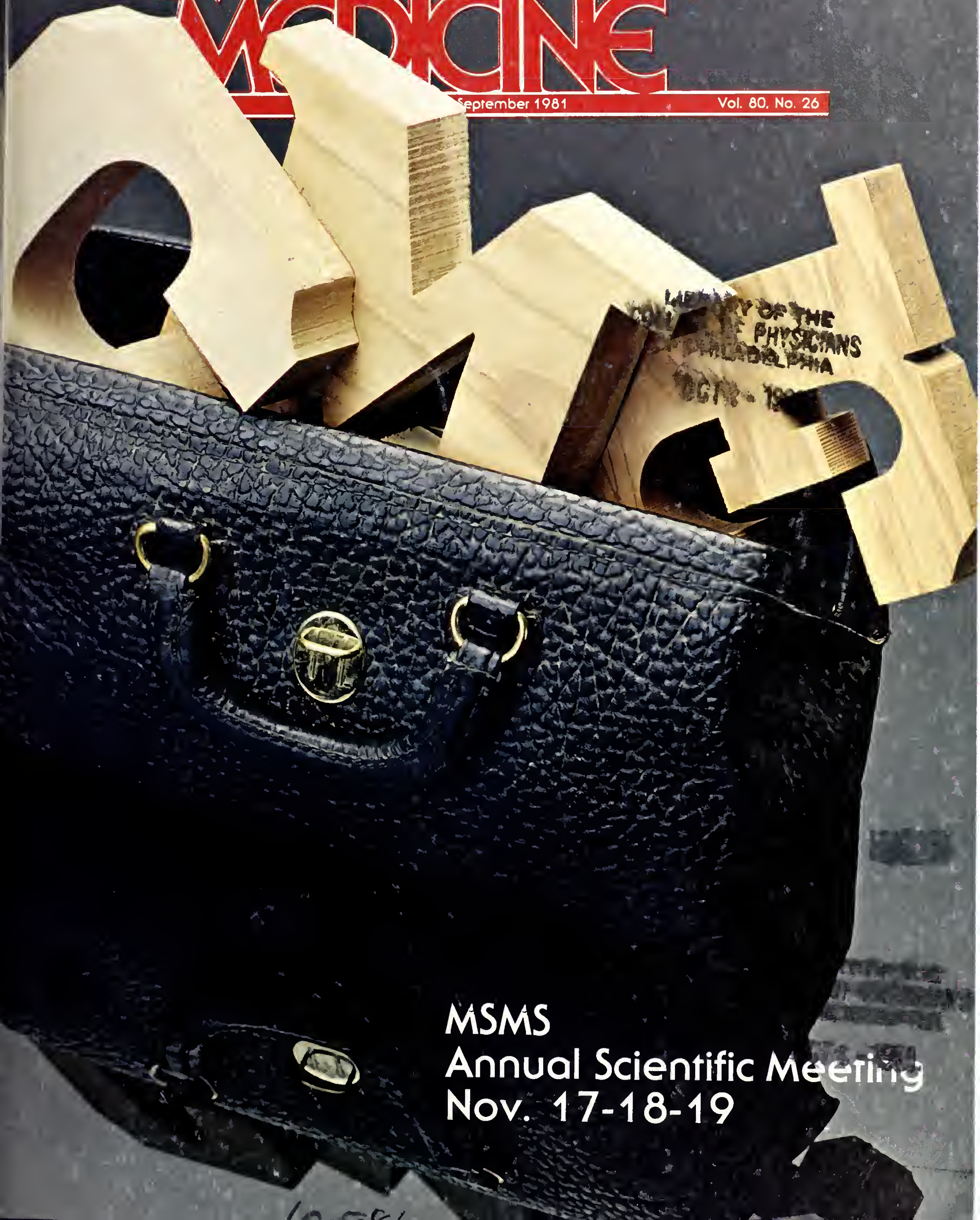
Doctor Eliot is a professor of medicine at the University of Nebraska and director of the UN Cardiovascular Center.

His interest in stress and its effect on the cardiovascular system results from years of study, research and patient care. He has published more than 165 articles for professional medical journals and has edited several books on the subject of heart disease and stress for medical professionals. He is author of the text, *Stress and the Major Cardiovascular Disorders*, and is currently working on a practical and comprehensive book on the subject of stress management for the lay public.

He is a graduate of the University of Colorado School of Medicine. He is a member of the board of trustees of the American College of Cardiology and heads several national research groups studying the complexities of heart disease, lifestyle and stress management.

MICHIGAN MEDICINE

September 1981 Vol. 80, No. 26



LIBRARY OF THE
COLLEGE OF PHYSICIANS
PHILADELPHIA
OCT 1 - 19

MSMS
Annual Scientific Meeting
Nov. 17-18-19

"Check Our Low Pressure CME"

Raise your level of medical knowledge without raising your blood pressure by attending the 1981 MSMS Annual Scientific Meeting, November 17-18-19 at the Hyatt Regency Dearborn. You can choose from 57 different courses and earn up to 18 hours of Category I Credit. Excellent instructors! Great choices! Low cost! They all add up to quality CME that's guaranteed to keep your blood pressure in check. Plan now to join your colleagues at the 116th MSMS Annual Scientific Meeting.

1981
MSMS ANNUAL
SCIENTIFIC MEETING
November 17-18-19, 1981
Hyatt Regency Dearborn

The 1981 MSMS Annual Scientific Meeting Nov. 17-18-19 is the subject of this month's special report beginning on page 460. **(Photo by Roger Hill.)**

MICHIGAN MEDICINE

September 1981, Volume 80, No. 26

Special report

460 Doctor, you will outfit your medical arts bag anew when you attend the 1981 MSMS Annual Scientific Meeting Nov. 17-18-19 at the Hyatt Regency Dearborn. You will come away from the three-day array of 57 half-day courses with new diagnostic and treatment tools, your skills and knowledge enhanced and augmented. The special report in this issue provides all the details on courses, faculty, facilities, credits, costs and registration. Be sure to study the entire report and make your plans today.

Features

470 MSMS conference Nov. 4 to examine toll of stress in women's lives

473 Excerpts of an important article: "The health care industry and the antitrust laws: Collision course?;" H. Robert Halper

480 Cost-effective medicine; James E. McGillicuddy, MD

483 The impact of housestaff unionization; Craig L. Kippels, MBA; Deveraux S. Peterson, PhD, David R. Barton, MA

486 Michigan studies of aspirin, Reye's Syndrome; William Hall, MD

508 Doctor Potchen seeks better MD, RN working relationship; Charles R. Downs

510 Make plans today for annual MSMS Public Affairs/Leadership Conference

Departments

456 MSMS/A; Barbara Grennan

457 Letters

490 Medical newsfronts

495 New members

498 Category I courses

500 News

503 Meetings

504 Deaths

508 Ad index

509 Classified ads

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
OCT 5 - 1981

MSMS/A

October is leadership month!

By Barbara Grennan
Muskegon

October is leadership month for the MSMS Auxiliary. For auxilians, several opportunities will be available to provide leadership skills and experiences to those who take advantage of the workshops and seminars being offered.

On tap first for a limited number of county presidents-elect will be the American Medical Association Auxiliary sponsored CONFLUENCE. This two-day meeting Oct. 11-13 in Chicago offers guidelines, learning opportunities and idea-sharing sessions to those who will be assuming leadership roles within the next year.

Included in this year's agenda are leadership seminars on parliamentary procedure, preparation and delivery of speeches, building a winning team, coalitions, public relations, and how to make committees work. Topics of seminars will include "Help! I'm the Parent of a Teenager," stress management, substance abuse, home and street safety, "Aging: it happens to us all," and the family of the impaired physician.

Special speakers will be Daniel T. Cloud, MD, AMA President, who will speak on issues facing organized medicine; James H. Sammons, MD, AMA executive vice-president, who will cover socio-economic issues, and Eva Schindler-Rainman, DSW, an organizational and community consultant from Los Angeles, who will speak on volunteerism.

County presidents-elect will learn all they need to know about being a leader and state presidents and presidents-elect who also attend CONFLUENCE will meet in regional groups to discuss problems, concerns and ideas. CONFLUENCE is much acclaimed by those county presidents-elect who have previously attended.

Also on tap in October is the MSMS Auxiliary Fall Education Conference scheduled Oct. 21 at the Lansing Hilton.

This meeting will offer an excellent leadership workshop to be conducted by E. Jackie Kenney of Indianapolis. At a similar workshop last February for state leaders Ms. Kenney did an excellent job of identifying leadership types, discussing their modus operandi and challenging their performance. She is a skilled workshop leader with much to offer both state and county leaders.

Ruth Gattman, North Central Regional Legislative Chairman of the AMA Auxiliary also will join us to participate in a legislative workshop and to speak on auxiliary membership. There will be additional workshops offered on AMA-ERF fund raising, communications, health projects and other auxiliary sponsored topics. Additional speakers are still being confirmed at this writing.

As a valuable plus this year, MSMS/A is coordinating its Fall Conference with MSMS Public Affairs/Leadership Conference. We hope this will provide additional incentive for auxiliary members and their spouses to make plans to attend. The MSMS conference offers invaluable information on many subjects to those who take time from their busy schedules to attend.

One auxiliary speaker has been included in the day's format. She is Indiana's Ruth Gattman (Mrs. G. Beech Gattman) who will cover Indiana's Voluntary Effort, a public service attempt at voluntary cost containment initiated by the Indiana State Medical Association and Auxiliary.

Auxiliary members should plan to attend both the MSMS/A session on Oct. 21 and the MSMS session on Oct. 22, and encourage their spouses to join them.

Mrs. Grennan is president of the MSMS Auxiliary

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
John R. Ylvisaker, MD, Pontiac

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $20.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. ©1981 Michigan State Medical Society.

LETTERS

Here's to PAs!

Michigan Medicine is to be complimented on its recent "Update on Physician's Assistants" in the May, 1981, issue. Timely information regarding PAs can help physicians and other members of the health care team to monitor the progress, contributions and current challenges of the profession as it enters its second decade in Michigan.

Some comment is called for, however, in response to Mr. Angell's generalization in the lead paragraph. Here he refers to PAs having "little acceptance, little recognition, lack of solidified identity," which is not borne out by the rest of the article. Indeed, all of his sources gave the physician assistant profession a positive endorsement in Michigan despite the growing pains that might be expected in any new endeavor. If additional proof is needed that the vast majority of PAs themselves feel good about their choice of profession, we need look no farther than a quote from a 1980 Mercy College study on job satisfaction among its graduates:

"The respondents' attitudes about their profession were very positive. Most PAs were very satisfied with the profession and their personal sense of accomplishment. They felt that PA training is important in their future; that they contribute to quality care; that they are growing personally; and that the PA concept is sound and here to stay. In general, 81 percent felt that the profession has lived up to their expectations in most or all ways."

While the program does not recruit students whose first career choice is to be a physician, it nevertheless recognizes that some of its graduates have felt the need for another level of responsibility in the practice of medicine. They have found medical school a doorway to upward mobility. Others have found advancement through master's degrees in education, public health, business administration, counseling and guidance, and gerontology. Some medical schools now actively recruit graduate PAs. Perhaps this is a compliment to the exceptionally fine preparation provided by both the Mercy College of Detroit and Western Michigan University Physician Assistant Programs.

In general, then, the marriage between PAs and the medical profession has been a cordial, productive and mutually respectful one. Here's to the second decade!

Harriet Gales, MA, FAPHA
Associate Professor &
Program Director
Physician Assistant Program
Mercy College of Detroit

More on PAs

I would like to comment on the Special Report titled "Update on Physician's Assistants" in the May issue of *Michigan Medicine*.

I have had the first-hand opportunity to work with three PAs. The PAs are functioning as true assistants to their primary supervising physician and are interacting with the physician on a daily basis concerning proper treatment and follow-up care plans. The "SOAP" method of charting is utilized and each physician monitors the PA by frequent evaluation of the completeness and appropriateness of chart entries. The PAs charts also are included in the peer review studies which are constantly being performed. Thus, through daily direct contact concerning appropriate patient care and the various modalities of chart review, a high quality of medical care is achieved.

The PA has freed the physician from some mundane tasks, but "mundane" physicals have turned up a high number of cancers, which would have been discovered months later if the patient had to wait until a physician was available to perform the exam.

One last comment concerning the prescribing by PA's should be made (sic). I feel given certain guidelines for specific diagnostic entities, a PA can prescribe appropriate drugs for an individual patient. The stepped-care regimen for the treatment and control of hypertension is a good example.

Thomas E. Lipps, MD
Chief of Family Practice
Group Health Service of Michigan
Saginaw

Psychotherapy insurance

Over the past few years, the Michigan Psychoanalytic Society and the Michigan Psychiatric Society have been seeking means for the establishment of equitable insurance coverage for psychotherapy. Recently, insurance coverage for psychotherapy for members of AFSCME has been reduced by the Aetna Insurance Company.

We have been told that Duane Marlan, Director, Employees Benefit Division of the Department of Civil Service, has expressed concern about the effect of this reduction and has been apprised that in a parallel circumstance, Blue Cross Blue Shield of Michigan chose to grandfather patients already in treatment.

Any patient so affected who feels that the reduction in benefits will adversely affect or prevent effective treatment, may write to Mr. Marlan explaining how the unexpected diminution in benefits can affect his or her treatment, career. He can be reached at the following address:

Duane Marlan, Director
Employees Benefit Division
Department of Civil Service
Lewis Cass Building
Lansing, 48909

Melvin Bornstein, MD, President
The Michigan Psychoanalytic Society

Emanuel Tanay, MD, President
The Michigan Psychiatric Society

Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) Ⓒ, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® ⓘⓥ
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

ROCHE®
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Come to the 1981 MSMS Annual Scientific Meeting!

Nov. 17-18-19
Hyatt Regency Dearborn

"The essentials will be stressed, the forest stripped away."

That is the metaphoric way in which David R. Rovner, MD, East Lansing, describes his course, "*New Developments in Diabetes*," planned for the 1981 MSMS Annual Scientific Meeting Nov. 17-18-19 at the Hyatt Regency Dearborn.

MSMS asked Doctor Rovner and the 56 other Annual Scientific Meeting course directors why practicing physicians would want to attend their courses.

MSMS also asked what information physicians could reasonably expect to take away from the courses to help them deal more effectively with patients, and what is unique and exciting about the courses.

Their responses mirror the course directors' excitement in putting together the best possible presentations for Michigan doctors.

What is unique or exciting about their courses? Here are some answers:

"Exposure to some of the frontline pioneers in the care of the geriatric patient." — Jack F. Sanders, MD, Alma, "*Aging – Should We Treat It?*"

"The faculty of outstanding experts in the field of lung cancer treatment." — J. C. Rosenberg, MD, Detroit, "*Current Approaches to the Treatment of Lung Cancer.*"

"Patients with illustrative problems will be presented." — Joseph C. Honet, MD, Detroit, "*Arm Pain and Dysfunction: Diagnosis and Management.*"

"This course includes a workshop which will enable the physician to practice his skills under the supervision of a pulmonary disease specialist." — Samuel M. McMahon, MD, East Lansing, "*Pulmonary Function Studies and Arterial Blood Gases.*"

The Hyatt Regency Dearborn

Why should a practicing physician want to attend?

"Problems with improper drug use in the elderly are very common. As the population of the United States grows older it will become even more of a problem." — G. L. Royer, Jr., MD, Kalamazoo, "*Drugs in the Elderly*."

"The attendee will have access to very new information. This course will present the latest in cardiopulmonary/cerebral resuscitation protocols. This information is unpublished or will be recently published in the medical literature." — Richard M. Nowak, MD, Detroit, "*Cardiopulmonary/Cerebral Resuscitation*, 1981.

"Injuries occurring on the roadway are the leading cause of death from ages one to 44. It behooves physicians to learn about the epidemiology of this major public health problem . . . The physician will learn how to survive a highway crash. We hope he or she then will convey this information to patients." — Paul W. Gikas, MD, Ann Arbor, "*Causes and Prevention of Highway Injury*."

"Many genetic diseases are treatable and/or preventable, and common. The application of simple genetic principles in selected families offers the physician a unique opportunity to define individuals at high risk for a particular disease, and by early diagnosis and intervention, to prevent serious clinical illness." — Thomas Gelehrter, MD, Ann Arbor, "*Medical Genetics for the Practicing Physician*."

The interesting and invaluable information being prepared for Michigan physicians who attend the Annual Scientific Meeting flows on and on from the course directors' descriptions.

Their precise and dramatic presentations are the reason the three-day meeting is one of the largest staged in the country by a state medical society. Annually, approximately 1,500 Michigan physicians register for and attend the courses.

A total of 18 Category I CME credit hours may be earned by attendance all three days. The Hyatt Regency Dearborn setting ensures amiable, accessible surroundings, with easy parking available. Most courses are clustered together in one wing of the hotel, where MSMS registration and educational and commercial exhibits also are housed.

Again this year, the hotel will offer a luncheon daily in the MSMS exhibition hall. Coffee breaks and the traditional end-of-the-day MSMS "beer busts" also will take place in the exhibition hall, to give physicians time to browse and learn.

The Annual Scientific Meeting is planned and coordinated by the ASM Task Force to the MSMS Committee on CME Programming. Leading the Task Force since the close of the 1980 meeting has been Frank Cox, MD, director of the Office of Continuing Medical Education at Henry Ford Hospital, Detroit.

Physicians are urged to register early. The registration form appears on page 468 of this issue, and will follow in the Sept. 18 *Medigram*.

Those needing room reservations are urged to contact the Hyatt Regency soon and let the reservations clerk know they are part of the MSMS conference, to take advantage of the special room rate. Physicians may make room reservations directly before Oct. 26 by calling the Hyatt at 313/593-1234.

Here's the roster of course directors for scientific meeting

They plan the courses, arrange for faculty members, and lead the presentations.

Alexander

Aronow

Blumer

Brody

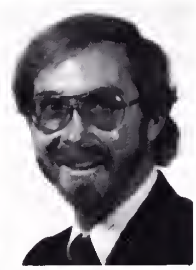
Bryant

Cohn

Coran

Danek

Davies



Downs

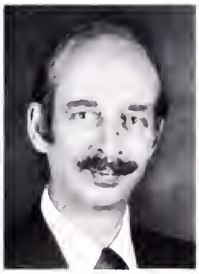
Drukker

Farah

Gelehrter

Gikas

Graham



Guise

Haas

Heideman

Honet

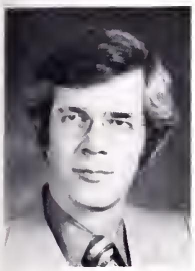
Johnson

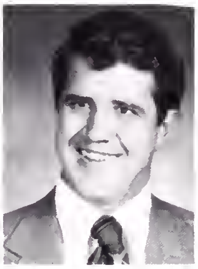
Kelsch

Lechner

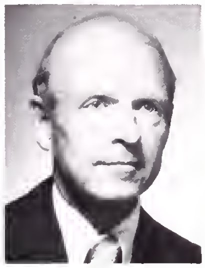
Mayle

McCabe


McDonald


McGillicuddy

McMahon


Murray

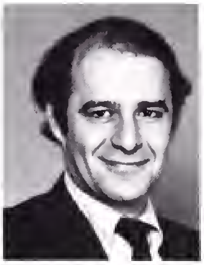
Nowak

Papp

Petrocelli

Quinones

Rosenberg

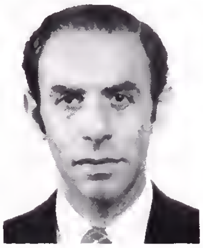

Roth

Rovner

Royer

Sanders

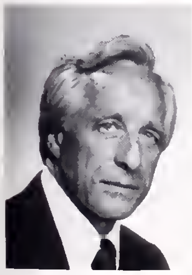
Saper


Schteingart

Simpson

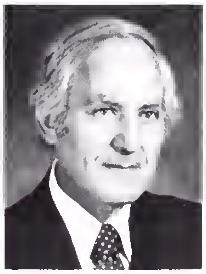
Smith

Stone


Suhrland

Thomas

Tourkow


Walt

Zorick

Please register for courses on page 468

Michigan specialty societies schedule events during Scientific Meeting

While the big 1981 MSMS Annual Scientific Meeting is underway at the Hyatt Regency Dearborn Nov. 17-18-19, Michigan specialty societies and other medical groups have an opportunity to schedule special events.

Dinners, luncheons, receptions and business meetings take place during the Annual Scientific Meeting, as the medical specialty societies take advantage of the crowds of their members who are drawn to courses during each of the three days.

Alumni and special medical interest groups jump on the bandwagon, too.

The 1981 meeting will have nine medical specialty events spread over the three-day schedule.

They begin with a reception and dinner Tuesday evening Nov. 17, planned by the Michigan College of Nuclear Medicine Physicians. The MCNMP will meet in the Royale Suite of the hotel.

On Wednesday, several specialty societies will gather. Specialties, type of meeting and suite follow:

Michigan Allergy Society, 10 a.m. executive committee meeting;

Michigan Society of Obstetricians and Gynecologists, noon luncheon;

Michigan Otolaryngological Society, reception and dinner, Bugatti-Royale Suite;

Michigan Society of Colon and Rectal Surgeons, reception and dinner, Atlanta Suite;

Michigan Society of General Surgeons, dinner and reception.

On Thursday, the Michigan Ophthalmological Society will hold a reception and dinner in the San Francisco Suite.

Wayne State University School of Medicine Alumni again will hold their popular reception Wednesday evening during the Annual Scientific Meeting. They will be in the Stearns Knight Suite.

Another special event of the Annual Scientific Meeting will be a luncheon gathering Wednesday of Women Physicians In Michigan, in the Rolls Royce Suite.

Alumni and faculty from the three medical schools in Michigan will be on hand as special guests at coffee breaks and "beer busts" each day, to mingle with the physicians attending Annual Scientific Meeting courses. The "beer busts" are a congenial, beer-and-talk time for participants, course directors and faculty, when the events and medical/scientific reports of the day can be discussed in an informal setting.

The "beer busts" are scheduled from 4:30 to 5:30 p.m. each day, as courses end, in the exhibition hall. Approximately 75 commercial and educational exhibitors will be on hand to display their products and services for interested physicians in that hall, where registration also takes place.

Special guests for the Tuesday, Nov. 17 "beer bust" will be Michigan State University College of Human Medicine alumni and faculty. On Wednesday, Nov. 18, the "beer bust" special guests will be Wayne State University School of Medicine alumni and faculty. And for the Thursday, Nov. 19 "beer bust" it will be the University of Michigan Medical School alumni and faculty on hand.

During the Tuesday afternoon coffee break, members of the American Association of Medical Assistants, State of Michigan Branch, will host the coffee break from 1:30 to 3 p.m.

The Annual Scientific Meeting is a gathering of 1,500 Michigan physicians who have the chance to meet former classmates, make new friends and enjoy the fine hotel facilities, as well as learn the latest medical developments.

At-a-glance schedule of special events at Scientific Meeting

Tuesday evening, Nov. 17 — Michigan College of Nuclear Medicine Physicians
Wednesday morning, Nov. 18 — Michigan Allergy Society
Wednesday noon, Nov. 18 — Michigan Society of Obstetricians and Gynecologists
— Women Physicians in Michigan
Wednesday evening, Nov. 18 — Michigan Otolaryngological Society
— Michigan Society of Colon and Rectal Surgeons
— Michigan Society of General Surgeons
— WSU Medical Alumni
Thursday evening, Nov. 18 — Michigan Ophthalmological Society

★ Out-of-state speakers add lustre to scientific faculty

"The Michigan Otolaryngological Society is privileged to present an international team of renown who will discuss the medical and surgical aspects of vertigo!"

Show business?

No, it's the enthusiastic buildup of Course Director Arnold M. Cohn, MD, and the Michigan Otolaryngological Society for their course at the 1981 MSMS Annual Scientific Meeting Nov. 17-18-19 at the Hyatt Regency Dearborn.

Their excitement is typical for planners of the Annual Scientific Meeting's "really big show" for Michigan physicians.

For many, the electricity sparks for the out-of-state physicians who key the discussions. The national and international experts who speak at the meeting are among the star attractions of the three-day event.

The "international team of renown" of Doctor Cohn's course includes University of Toronto faculty members Hugh O. Barber, MD, and Julian Nedzelski, MD. They both are with the Sunnybrook Medical Centre of the University, where Doctor Barber is head of, and Doctor Nedzelski is consultant for, the Department of Otolaryngology.

25 out-of-state

They are two of the approximately 25 out-of-state speakers among the 175 faculty members for the Annual Scientific Meeting.

Others and their topics are:

★ Lawrence W. Friedmann, MD, chairman, Department of Physical Medicine and Rehabilitation, Nassau County Medical Center, East Meadow, NY, and professor of rehabilitation, State University of New York at Stony Brook, "Lower Extremity Amputations;"

★ Robert S. Sanders, MD, chairman, Accident Prevention Committee, Tennessee Chapter, American Academy of Pediatrics and director, Rutherford County Health Department, Murfreesboro, TN; "The Tennessee Experience with Child Restraint Legislation;"

★ Arthur Pappas, MD, professor and chairman, University of Massachusetts Medical School, "The Elbow in Throwing Sports in the Child and Adolescent;"

★ Michael I. Greenburg, MD, clinical assistant professor of surgery, Section of Emergency Medicine, Medical College of Pennsylvania, and chief of emergency medicine at Sacred Heart Hospital, Norristown, PA; "Endotracheal Drug Administration;"

★ Myron Pollycove, MD, professor of Laboratory Medicine and Radiology, University of California at San Francisco; director, Clinical Laboratories, and chief of nuclear medicine at San Francisco General Hospital Medical Center, "Radionuclides in the Preoperative Evaluation of Patients with Malignancy;"

★ Robert W. Beart Jr., MD, assistant professor of surgery at Mayo Medical School and head, Section of Colon and Rectal Surgery, Mayo Clinic, Rochester, MN, "Surgical Alternatives in the Treatment of Inflammatory Bowel Disease;"

★ Robert Livingston, MD, chief of oncology at Cleveland Clinic, "Chemotherapy for Lung Cancer: Oat Cell and Non-Oat Cell;"

★ Arthur F. Kohrman, MD, director, Larabida Children's Hospital and Research Institute, and professor, University of Chicago Department of Pediatrics, "The Treatment of Insulin Dependent Diabetes;" and

★ Charles Reed, MD, Section of Allergy, Mayo Clinic, Rochester, MN, "The Role of Infection and Airway Hyperirritability in Bronchial Asthma."

Whole course

One of the Annual Scientific Meeting Courses, "Drugs in the Elderly," will feature a faculty of out-of-state speakers, except for one; Edward Domino, MD, professor of pharmacology at the University of Michigan.

The out-of-state speakers in that course are:

★ Robert Vestal, MD, assistant professor of medicine, Boise VA Hospital, Idaho, "An Overview of the Problems and Some of the Solutions regarding Drug Therapy in the Elderly;"

★ Michael Weintraub, MD, associate professor of pharmacology and toxicology, Strong Memorial Hospital, University of Rochester Medical Center, Rochester, NY, "The Use of Analgesic Therapy in the Elderly Patient," and

★ Joan Data, MD, PhD, senior clinical research scientist, Burroughs Wellcome Company, Research Triangle Park, NC, "The Use of Cardiovascular Drugs in the Elderly."

Further details on this star-studded cast are available from Sherry Fent at MSMS headquarters.

Commercial, educational exhibitors support the Annual Scientific Meeting

What is Upjohn up to?

What kind of an offer can the Michigan Physicians Mutual Liability Insurance Company make on malpractice insurance?

What are the latest laws on prescription drugs?

Are Army, Air Force and Navy recruiters making armed service medical careers sound like a pretty good deal nowadays?

If you're a Michigan physician who would like answers to some of those questions, come to the 1981 MSMS Annual Scientific Meeting Nov. 17-18-19 and start asking.

Over 70 commercial and educational exhibitors will array their wares and their messages for the benefit of Michigan physicians who attend the three-day MSMS continuing medical education meeting.

The commercial exhibitors range from Gerber Products Company to Texas Instruments, and include specialized laboratories, medical supply houses, computer and business instruments companies, drug companies, insurance companies, Michigan Bell, Encyclopedia Britannica and the three branches of the armed services.

The educational exhibits will describe burn care, food and drug rules and regulations, emergency medicine, the growth of hospices in Michigan, and alcholism treatment in Michigan.

CME course directors will schedule half-hour coffee breaks morning and afternoon, when physicians may visit the booths. The hotel offers a buffet luncheon each day in the exhibit hall, making visits to booths handy at that time. And, at the end of each day's activities, the MSMS "beer busts" will be staged in the hall, when all exhibits are open and ready for business.

MSMS is pleased to have the following exhibitors for this Annual Scientific Meeting.

Educational exhibits:

Children's Hospital of Michigan Burn Center
Food and Drug Administration
Michigan Chapter, American College of Emergency Physicians
Michigan Hospice Organization
National Council on Alcoholism.

Commercial exhibits:

Advance Medical and Research Center
Allied Integrated Diagnostic Services
American Electromedics Corporation
Binson's Hospital Supplies, Inc.
Blue Cross Blue Shield of Michigan
Boehringer Ingelheim
City X-Ray Company
Comedco, Inc.
Comp-u-med
Continental Bio-Clinical Laboratory Service
Dart Medical
Data-Med Corporation
Dearborn Clinical Laboratory, Inc.
Dista Products Company
Diversified Coin-Vest, Ltd.
DOCS
E & M Medical Systems, Inc.
Encyclopaedia Britannica
Equity Programs, Inc.
Ferndale Laboratories
Firestone X-ray Corp.
First Heritage Corporation
Gerber Products Company
Healthways, Inc.
International Medical Electronics, Ltd.
Kelly Health Care
Laboratory Procedures, Inc.
Laboratory Science Division/Master Medical
Light Com, Inc.
Eli Lilly & Company
McCullagh Leasing, Inc.
Mead Johnson Nutritional Division
Medical Information Systems, Inc.
Medical Plastics Laboratory, Inc.
The Medical Protective Company
MEDS Marketing, Inc.
Merck Sharp and Dohme
Merrell Dow Pharmaceuticals, Inc.
MESSA
Metpath, Inc.
Michigan Bell
Michigan Ophthalmological Society
Michigan Physicians Mutual Liability Company
Milex of Michigan, Inc.
Omni-American
Paradata of Michigan, Inc.
Parke-Davis
Proctor and Gamble
Reed and Carnrick Pharmaceuticals
Rollins Medical/Dental Systems
Rourk Medical Services Corporation
W. B. Saunders
Schering Corporation
Smith Kline and French Laboratories
Sonar Professional Service
Stratton-Cheeseman and Associates, Inc.
Syntex Laboratories, Inc.
Systemedics Association, Inc.
Texas Instruments
3 PM-WECO
Troy Biologicals
United Medical Services
United States Air Force
United States Army
United States Navy Recruiting Command
The Upjohn Company

What to expect at the 1981 MSMS Annual Scientific Meeting

Advanced Cardiac Life Support taught in new place, at new time

Advanced Cardiac Life Support is always a popular course at the MSMS Annual Scientific Meeting.

But because it is run separately from the rest of the three-day continuing medical education meeting, this year it will be truly separate, in dates and location, too.

The MSMS ACLS course for 1981 will be held Dec. 4-5-6 at Lansing Community College. Physicians who enroll in the Basic Cardiac Life Support course Wednesday or Thursday morning during the Annual Scientific Meeting, will have first choice for enrollment in the subsequent ACLS course.

Further details and registration forms specially for the Advanced Cardiac Life Support Course in Lansing will follow soon in *Medigram* and *Michigan Medicine*.

A busy, attractive exhibition hall . . .

DETROIT
PLAZA
LUCCHESI
SORKIN
DAS

ull classrooms of attentive Michigan physicians . . .

hands-on instruction.

PLEASE SEND ENTIRE PAGE WITH CHECK

1981 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn
Registration form for Category I CME Courses

ALL COURSES ARE APPROVED BY THE AAFP FOR EITHER PRESCRIBED OR ELECTIVE CREDIT.

TUESDAY MORNING, NOV. 17
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

- _____ Alcoholism: Treatment Resources
- _____ Back and Neck Pain
- _____ Common Nephrological Problems in Clinical Practice
- _____ Current Management of Vascular Disease
- _____ Drug Therapy in the Elderly: A Clinical Approach
- _____ Nuclear Medicine and the Practicing Physician
- _____ Occupational Medicine — Part of Every Physician's Practice
- _____ Pulmonary Rehabilitation: A Comprehensive Approach to COPD
- _____ The Wet Ear — Causes and Management
- _____ Why Educate Patients? Why Not?

TUESDAY AFTERNOON, NOV. 17
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

- _____ Causes and Prevention of Highway Injuries
- _____ Chronic Abdominal Pain
- _____ Clinical Problems within the Family Life Cycle
- _____ Medical Genetics for the Practicing Physician
- _____ New Dimensions in the Diagnosis and Treatment of Stroke
- _____ New Topics in Infectious Diseases
- _____ Problems in Contemporary Pediatrics
- _____ Psychotherapy in Medical Practice
- _____ Systematic Approach to Preventing Patient Injury
- _____ The Poisoned Patient
- _____ Workshop on Pulmonary Function Studies and Arterial Blood Gases

WEDNESDAY MORNING, NOV. 18
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

- _____ Aging — Should You Treat It?
- _____ Basic Cardiac Life Support
- _____ Cleft Lip and Palate (part I)
- _____ Common Problems in Pediatric Surgery
- _____ Depression: Modern Concepts in Recognition and Treatment
- _____ Dermatology for the Non-Dermatologist
- _____ Diagnosis and Management of Non-Ulcer Gastrointestinal Bleeding
- _____ Indication and Preparation for Gynecologic Surgery
- _____ Primary Care Internal Medicine — Selected Topics
- _____ Respiratory Therapy — Boon or Boondoggle

WEDNESDAY AFTERNOON, NOV. 18
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

- _____ Advances in Treatment of Cell Lung Cancer
- _____ Athletic Injuries to School Children and Adolescents
- _____ Cardiopulmonary/Cerebral Resuscitation — 1981
- _____ Cleft Lip and Palate (part II)
- _____ Current Topics in Allergy
- _____ Male Sexual Dysfunction: The Current Concepts, Diagnosis and Management
- _____ Malignant Melanoma: Diagnosis and Prognosis
- _____ Medical and Surgical Aspects of Vertigo
- _____ New Concepts in Management of Sleep Disorders
- _____ New Developments in Diabetes Mellitus and How They Affect Therapy
- _____ Symposium on Inflammatory Bowel Disease

THURSDAY MORNING, NOV. 19
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

- _____ Arm Pain and Dysfunction — Diagnosis and Management
- _____ Basic Cardiac Life Support
- _____ Carcinoma of the Breast: The Scene in 1981.
- _____ Headache Management and Mismanagement
- _____ Hospice: A Challenge to Physicians
- _____ Mild Hypertension — Approach to Diagnosis and Management
- _____ Stroke and the Eye

THURSDAY AFTERNOON, NOV. 19
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

- _____ Current Concepts in Management of Electrolyte Disorders
- _____ Lower Extremity Amputations — From Surgical Planning through Prosthetic Rehabilitation
- _____ Management of Angina Pectoris: The Role of Bypass Surgery and Angiography
- _____ Medical Ethics: Communication and Truth in the Doctor-Patient Relationship
- _____ Multidisciplinary Management of Obestiy
- _____ Ocular Trauma
- _____ Preventive Oncology for the Practitioner
- _____ Treatment of Cardiac Arrhythmias

The half-day courses will provide 3 hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, *please indicate a second choice* should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets, must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/26/81 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

Name ____
(please print) (first) (initial) (last)

Street ____

City, State ____________________________ Zip __________

MSMS Member: Yes ____ No ____ Resident ____ Other ____ Specialty __________

Tuition schedule for courses:
MSMS members: $5 per credit hour, or $15 for each half-day course
Non-members: $10 per credit hour, or $30 for each half-day course
Residents: $5 PER COURSE

Luncheon reservations: The hotel will provide buffet luncheon each noon at $9 per person Advance reservations are requested so MSMS can give an accurate guarantee. Please indicat which days you want a lunch ticket.

- Tuesday lunch ________ Wednesday lunch ________ Thursday lunch ________

• Indicate total number of half-day courses:	________	× $15 (members)	$ ________
	________	× $30 (non-members)	$ ________
	________	× $5 (residents)	$ ________
• Number of luncheons requested:	________	× $9	$ ________
		• TOTAL	$ ________

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823

OVER 4,000 POLICYHOLDERS

In five years, we have grown from an idea—to a company insuring over 4,000 physicians with our MEDGARD: PROFESSIONAL LIABILITY, BUILDING/OFFICE PACKAGE, and UMBRELLA coverages. We believe there are good reasons for this. And we'd like to thank the thousands of Michigan Physicians who have supported us.

THANK YOU MICHIGAN PHYSICIANS

THE MEDGARD COMPANY

MEDGARD is not only the name of our policies . . . it represents the major part of MPMLC's philosophy of providing services to physicians. Our insureds have purchased these services to guard their homes, autos, offices, equipment, and, most important, their professional reputations in the event of a claim.

ENDORSED BY ORGANIZED MEDICINE

MPMLC is endorsed by both MSMS and MAOP&S. A distinction not easily gained, nor given to any other carrier which provides professional liability coverage for physicians.

PHYSICIAN OWNERSHIP AND CONTROL

MPMLC is your company. It is owned by physicians and run by physicians. Our Board of Directors is comprised of your colleagues who have practiced medicine in Michigan for years. Several are leaders in other professional organizations at the state and national levels.

EXCELLENT CLAIMS SERVICES

"Keep up the good work"
"Outstanding"
". . . hold MPMLC in high regard."

These are comments from physicians who responded to our Closed Claim Questionnaire. We don't tell you after a claim has been settled. We ask you for your consent first.

YOUR COMPANY THANKS YOU

So thank you Michigan physicians for working with us and believing in the concept of your company. We will continue to provide the professional services, diverse coverages, and responsive management which you have supported.

**Michigan Physicians
Mutual Liability Company**

Watch for special announcements about our CME Category I risk management seminar at the MSMS Annual Scientific Meeting. See you in November at the Dearborn Hyatt Regency—Booth 502.

HOME OFFICE. P.O. Box 1471 · East Lansing, MI 48823 · (517) 351-1150 · (800) 292-1926 toll free
SATELLITE OFFICE: 6735 Telegraph Road · Suite 205 · Birmingham, MI 48010 · (313) 647-5550

Effects of stress on women topic of MSMS conference Nov. 4

Doctor Eliot

The standard risk factors are implicated in about 50 percent of the new cases of cardiovascular disease.

What about the other 50 percent?

How are psychosocial stress, Type A behavior, and the central nervous system important in the etiology of cardiovascular disease?

Those are the questions of Robert Salim Eliot, MD, Omaha, keynote speaker for the new MSMS health issues conference, "Stress and the Contemporary Woman," scheduled Nov. 4 at Long's Convention Center, Lansing.

The conference has been approved to award six Category I credit hours and six American Academy of Family Physicians prescribed credits.

Currently there is increasing interest in the role of stress as an etiological factor in cardiovascular disease, points out Doctor Eliot. The growing incidence of cardiovascular disease among women in the US will be one of the subjects explored during the day-long conference.

Sustained, unresolved, emotional stress may lead to such changes as readjustment in the autonomic nervous system and to elevation of catecholamine levels in the circulation, continues Doctor Eliot.

In animals, these maladaptations can result in various deleterious cardiovascular effects, including hypertension, myocardial necrosis and arrhythmias, among others. Evidence is developing that indicates humans experience the same.

Stress points

Conference Chairman Marguerite Shearer, MD, Dexter family physician, and her assistants, Sherry N. Wellman and Ellen Vinocur Potash of the MSMS staff, are organizing the conference around several major circumstances which create stress in American women's lives.

Titles of the talks planned include "Critical Decision Points in Life," "Discrimination and Women," "Identification and Management of Stress," and "Reproductive Issues and Sexuality."

Other speakers include Kathryn McAuliffe, MD, Lansing family practitioner; F. Paul Pearsall, PhD, chief, Problems of Daily Living Clinic, Sinai Hospital of Detroit; Susan E. Adelman, MD, Southfield surgeon; Linda J. Logsdon, MD, Southfield psychiatrist; and Marshall L. Shearer, MD, Ann Arbor psychiatrist. Moderators will include Louis R. Zako, MD, Dearborn Heights family practitioner; Patricia Leuzzi, assistant director, Michigan Women's Commission, Lansing; Thomas Berglund, MD, Portage family practitioner; Gerald Holzman, MD, Michigan State University Department of Obstetrics and Gynecology, and Janice Gross, MPH, Office of Health and Medical Affairs, Lansing.

What can physicians do about 20th century stress?

Doctor Eliot suggests evaluations and interventions must include the more complex humanistic issues of behavior, lifestyle and quality of life. In order to help patients achieve better quality of life, he says, physicians must address the following items:

- Identifying realistic goals,
- Establishing priorities,
- Modifying potentially self-destructive behaviors,
- Reducing the frequency and number of disruptive life changes,
- Relaxing or meditation,
- Aerobic exercise,
- Group therapy,
- Appropriate use of leisure time, and
- Medications.

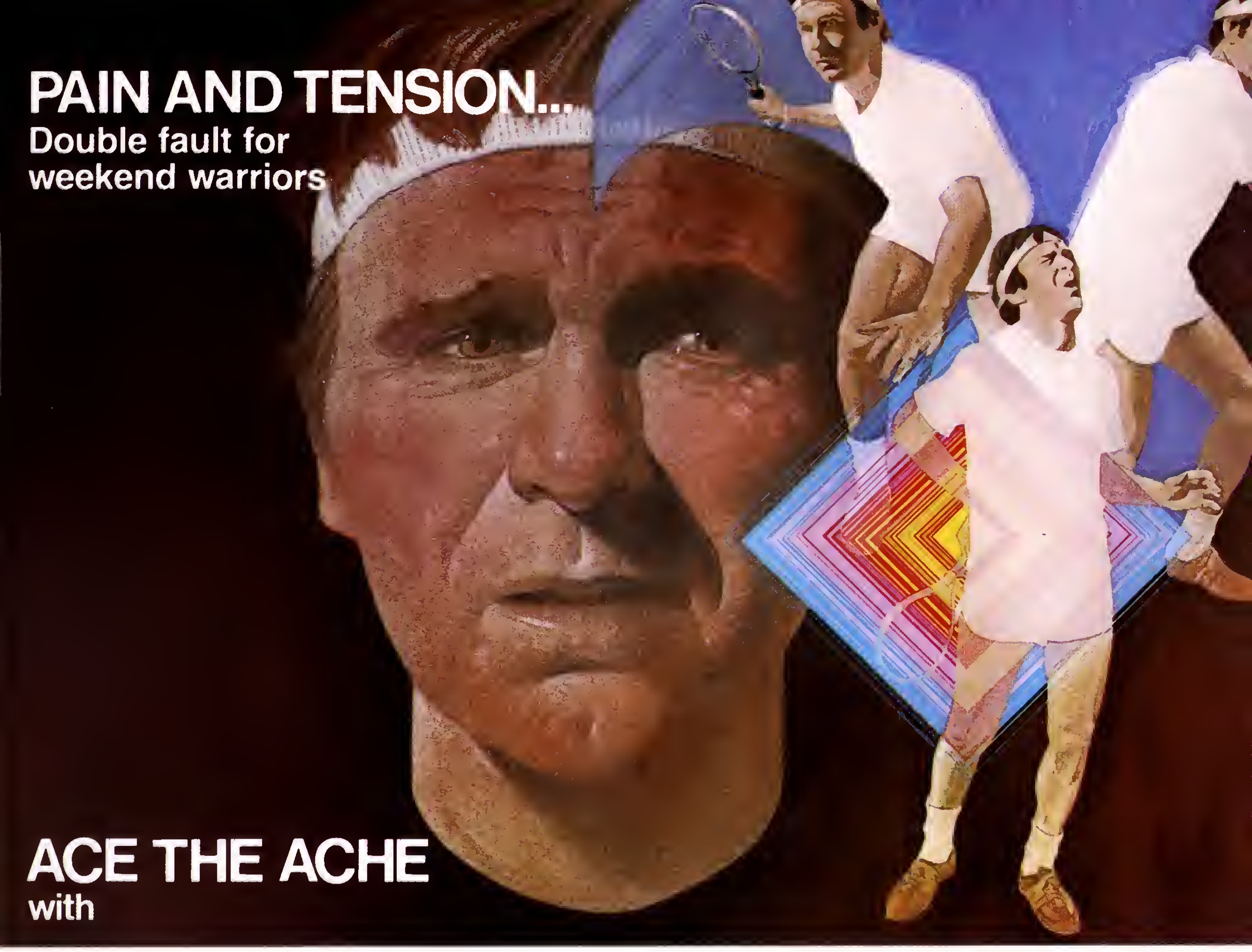
Doctor Eliot

Doctor Eliot's presentation will help physicians help their patients find ways to be productive without being self destructive. His presentation will relate directly to everyday work and leisure activities.

Doctor Eliot is a professor of medicine and chairman of the Department of Preventive and Stress Medicine, and director of the Cardiovascular Center, at the University of Nebraska Medical Center, Omaha. His education included pre-medicine at Northwestern University and the University of New Mexico.

Prior to accepting appointments with the University of Nebraska in 1972, Doctor Eliot held teaching and faculty appointments at the University of Minnesota and the University of Florida, and was also a consultant in cardiology to NASA.

Doctor Eliot is a member of the Board of Trustees of the American College of Cardiology and heads several national research groups studying the complexities of heart disease, lifestyle, and stress management.


PAIN AND TENSION...
Double fault for weekend warriors
ACE THE ACHE
with

Equagesic®Ⓒ IV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

***INDICATIONS**: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e., more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS. A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1981, Wyeth Laboratories
All rights reserved

*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, PA 19101
TM

Down with pain
Step up to reliable relief

for mild to moderate pain

Wygesic® Ⓘⓥ

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene…all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary

INDICATION For the relief of mild-to-moderate pain

CONTRAINDICATION Hypersensitivity to propoxyphene or to acetaminophen

WARNINGS. CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol tranquilizers sedative-hypnotics or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts as well as misuse of tranquilizers alcohol or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)

DRUG DEPENDENCE. Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

USAGE IN AMBULATORY PATIENTS Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks e g driving a car or operating machinery Patients should be cautioned accordingly

USAGE IN PREGNANCY Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore propoxyphene should not be used in pregnant women unless in the judgement of the physician the potential benefits outweigh the possible hazards

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group

PRECAUTIONS: Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants including alcohol

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness sedation nausea and vomiting These seem more prominent in ambulatory than in nonambulatory patients some of these reactions may be alleviated if the patient lies down

Other adverse reactions include constipation abdominal pain skin rashes light-headedness headache weakness euphoria dysphoria and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported

DRUG INTERACTIONS: Propoxyphene in combination with alcohol tranquilizers sedative-hypnotics and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine

MANAGEMENT OF OVERDOSAGE SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume Cheyne-Stokes respiration cyanosis) extreme somnolence progressing to stupor or coma pupillary constriction and circulatory collapse In addition to these characteristics which are reversed by narcotic antagonists such as naloxone there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported and apnea cardiac arrest and death have occurred

Symptoms of massive overdosage with acetaminophen may include nausea vomiting anorexia and abdominal pain beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms the patient may feel less ill however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity jaundice coagulation defects hypoglycemia encephalopathy coma and death may follow Renal failure due to tubular necrosis and myocardiopathy have also been reported

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists naloxone nalorphine and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered preferably I V simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory In addition to a narcotic antagonist the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions

Oxygen IV fluids vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine which may cause anorexia nausea vomiting and drowsiness Appropriate literature should be consulted for further information (JAMA 237 2406-2407 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

Copyright © 1981, Wyeth Laboratories.
All rights reserved

Wyeth Laboratories
Philadelphia, PA 19101

TM

The health care industry and the antitrust laws: on a collision course?

By H. Robert Halper
Washington, DC

This article is excerpted, with permission, from the *Antitrust Law Journal* of the American Bar Association Section on Antitrust Law, Vol. 49, No. 1, 1981.

It is reprinted here at the suggestion of MSMS legal counsel and provides valuable insight to the legal side of current medical practice, in the wake of the recent FTC decision charging MSMS with antitrust violations. The MSMS case is cited in this article.

It is said that more scientific breakthroughs have occurred in the last decade than in all of previously recorded history.

Antitrust (law practices) in the health care field can borrow a page from science's book of compressed modern history. Virtually all significant developments have come within the last five years — and the pace of antitrust decision-making in the field is accelerating. By rough count, five times as many health antitrust actions have been brought since the epic *Goldfarb* decision in 1975, than during the previous 85 years of Sherman Act history. (The number of hospital and health lawyers taking crash antitrust courses, and antitrust lawyers attending health law seminars probably has increased one hundred fold.)

Amid these fast-paced developments, the ground rules have changed drastically, and the antitrust exemptions and defenses previously available to health care professionals, providers and insurers have eroded, if not been eliminated.

Four reasons

Why all this litigation activity? Let me suggest four reasons.

First, the health care industry is gigantic and occupies an increasing share of our total economy. With 1979 health care expenditures in excess of $212 billion; with these expenditures representing nine percent of the Gross National Product; and with the health care industry, measured in employment terms, reportedly the country's second biggest, its participants could not expect to escape meaningful antitrust scrutiny much longer.

Second, the health care industry is different. Only vaguely similar to a free industrial market, the hospital and other service demands are determined by physicians, not consumers, and are fueled by the prevalence of government and private third-party insurance, which frequently reimburses on the basis of cost. This has resulted in a wild escalation in health expenditures, both past and continuing, that has made the industry a likely area for challenge by federal and state antitrust enforcement agencies, and by private parties who are feeling the costs.

Third, the many regulatory strains affecting the health industry — licensing of professionals, certificate of need for hospitals, significant health reimbursement policies of regulated health insurers — also make possible, indeed, make certain, a vast amount of litigation centering around and testing the traditional antitrust defenses (*McCarran*-Ferguson, Noerr-Pennington and *Parker* v. *Brown*, the interstate commerce issue, and the scope of any learned profession exemption).

Fourth and finally, the critical reassessment of the professional's commercial interest in his calling, starting with *Goldfarb*, means that the physician's unique role in policymaking affecting his profession, his hospital, and his insurers is no longer untouchable.

In short, the era during which the health care delivery system had singularly avoided the type of antitrust attention and challenge that its economic impact and its size might otherwise have generated has ended. Health system participants, health professionals and societies, hospitals, third-party insurers, among others,

Mr. Halper is a member, O'Connor and Hannan, Washington, DC, and chairman, Health Care Committee, Section of Antitrust Law, American Bar Association.

now threaten to be engulfed by the flood of enforcement and private actions that have appeared in recent years.

At this point, in mid-1980, a valid question is whether laws and policies underlying the health care industry are on a collision course with the antitrust laws. I refer *not* to the ongoing collision in health policy between those who favor more regulation and the increasingly louder voices seeking more of the marketplace economy in health care. Rather, I mean the recent developments in the antitrust cases involving health and whether these rulings do violence either to traditionally accepted antitrust principles or to the twin objectives of the health care system: to provide quality care and to encourage the containment of otherwise skyrocketing costs.

I am going to address three primary areas which are illustrative of this "collision course" issue.

The first two, application of the antitrust laws to professional association activity, and the *Royal Drug* line of health insurance cases, could be viewed as areas where the confrontation has occurred and the antitrust laws seem to be emerging as the victor. Whether or not this apparent victory is genuine remains to be seen.

The third area, the relationship between the health planning laws and antitrust principles, presents an unresolved conflict, which will be a source for much comment, discussion and litigation in the future.

Professional associations

Goldfarb v. Virginia State Bar is the lodestar for all challenges that have been directed against health professionals and their associations. In holding a bar association fee schedule to be a per se violation, the Supreme Court in *Goldfarb* established that the "learned professions" were not exempt from the antitrust laws; that is, the public service aspects of a professional practice would not prevent scrutiny of anticompetitive activities of the members of a profession. *Goldfarb*'s famous footnote 17, however, held out hope to many that restraints in the context of a profession might still be distinguishable from business restraints.

National Society of Professional Engineers v. United States, a few years later, effectively extinguished most of this hope by cautioning that footnote 17 did not contemplate a broad exemption under the rule of reason for the learned professions. It established the key principle that professional self-regulation will be measured under an antitrust analysis that looks to whether the challenged policy or activity promotes or suppresses competition. Indeed, where fee or price-related restrictions are at issue, a "short form" rule of reason test may apply that is scarcely distinguishable from the per se test. Yet, in its aside that professional services may differ from other business services, the court may have provided still another quotable hope for remaining antitrust disbelievers.

With these two landmark cases in mind, let me categorize the types of antitrust challenges to the health professions that have been taking place into four groups of cases. Two groups deal with efforts to insulate the particular health care professional from "commercial" competition, and the other two involve challenges to professional activities affecting price.

More specifically, the first of these four categories involves concerted efforts to discourage professionals of the same discipline from practicing differently from the majority.

These activities of professionals usually are aimed at isolating the offending practitioner and enforcing the restrictive policy by either disciplinary action, peer pressure, withdrawal of medical cooperation, state licensing board involvement, or denial of hospital staff privileges. Inevitably, these efforts are fueled by the professional groups' fears of a new form of competition, or any competition at all, that could take away patients, put pressure on fees, or change the accepted economics of physician practice. In short, this category reflects the *intra*-professional fight of pharmacist against pharmacist, internist against internist, radiologist against radiologist.

The second group of cases, also aimed at consolidating control in the particular professional specialty, concerns the *inter*-professional struggle between the different medical specialties, or between one medical specialty and the allied health professional.

The third category of cases involves concerted indirect action affecting price. Attracting considerable attention from federal, and in particular state, governmental enforcement agencies, many cases in this group challenge joint action by medical societies, trade or professional associations, or other groups of practitioners or providers, which threaten to withhold professional or other health services in an effort to increase the reimbursement return coming to them from both governmental and private third-party insurers.[1] Included in this category are cases challenging joint efforts to interfere with the cost-containment activities of insurance companies, such as the concerted activities of dentists who collectively withheld dental x-rays in order to hinder the programs of certain dental insurers. The number of consent decrees entered leaves little doubt that professionals may be risking not only antitrust liability, but the very real possibility of criminal challenge in the future, under either federal or state antitrust laws.

The fourth and final category of commonly challenged professional actions involves concerted activities that impact directly on professional fees. The line of cases challenging the use of relative value schedules for physician specialties is perhaps the best-known example. The gathering of information for these schedules, their adoption and dissemination by

---

FOOTNOTE

[1] Michigan State Medical Soc'y, Docket 9129, *supra* note 23 (FTC complaint challenging the Society's efforts to compel Blue Cross and Blue Shield of Michigan to engage in collective bargaining and make concessions concerning cost containment mechanisms), See *also* United States v. South Carolina Health Care Ass'n, 1980-2 Trade Cas. ¶ 63,316 (D.S.C.) (consent judgment terminating joint bargaining and threatened boycott of State Medicaid program by nursing home operators); Michigan v. Warner-Universal Ambulance Serv., Inc., 1980-2 Trade Cas. ¶ 63,536 (Mich. Cir. Ct. Aug. 1980) (consent decree enjoining a boycott by ambulance companies serving the State Medicaid program).

continued on page 476

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When **impotence** is due to androgenic deficiency.

Android® /5 Buccal mg. /10 Oral mg. /25 Oral mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

medical specialty groups, and their use by specialist practitioners, have been attacked a number of times by the FTC and the Department of Justice as price fixing devices tending to standardize the fee actually charged for the service provided. These complaints have led to many settlements, including consent orders involving obstetricians and gynecologists, orthopedic surgeons, radiologists, and California and Minnesota physicians. Generally, the consenting organizations have agreed to cease publishing, participating in the development of, or circulating the relative value scales to their members.

Royal Drug

The second major area of development involves the line of health insurance cases which I call Royal Drug and its progeny. The short-run impact of *Group Life and Health Insurance Co. v. Royal Drug Co.* is monumental; the long range effect perhaps will not be so significant. By its opinion, the Supreme Court has virtually blocked the escape route of health insurance practices that, whether or not restrictive, under the protective cloak of the "business of insurance" language of the McCarran-Ferguson Act had avoided antitrust analysis by either the rule of reason or per se approach.

In *Royal Drug* the Court turned to the "business of insurance" language, and further gutted the defense. It held that certain pharmacy agreements between Blue Shield and participating pharmacies to provide drugs at their drug cost plus a $2 prescription fee, simply were not exempt as the business of insurance. "The business of insurance is not the same as the business of insurance companies," said the Court.

In the long run, *Royal Drug* and its progeny may have far less impact than imagined because of what the case did not decide. The Supreme Court did not hold that the Blue Shield drug prescription plan, or any comparable maximum reimbursement limit, amounts to an unreasonable restraint of trade.

Indeed, while health insurers, and therefore their subscribers, may have to bear the added costs of defending antitrust challenges, many should prevail at trial after demonstrating the reasonableness of their cost-containment restriction. Since so many cases strike at maximum fee reimbursement policies, we must await the real Armageddon in this type of litigation, a Supreme Court analysis on appeal from a fully litigated case. A new script may even be written by the Court on the quixotic and controversial maximum price fixing concept in the process.

Does all of this, then, establish a destructive collision between health law and antitrust principles? I for one believe not, at least until I read a Supreme Court opinion that strikes down what would appear to be a bona fide attempt by a non-monopsonist insurer to exercise its buying power in the interest of its subscriber-insureds.

Health planning

The third and final major topic to be discussed, the relationship between federal health planning laws and traditional antitrust principles, is the single most controversial issue in the field. The concurrent application of the antitrust laws and health planning laws has been an area of extreme tension for a number of years. Any hope that this tension has abated was shattered by a Department of Justice *Business Review Letter* on May 6, 1980, which impliedly is at odds with two lower court decisions currently on appeal.

Whether the antitrust laws should apply at all to health planning and how narrow any contemplated exemption should be are only two of the many issues. The fact is that for political and practical reasons Congress apparently has elected not to grant a complete exemption for all activities occurring in the planning process. That legislative decision heightens the suspense of the outcome when the two policies collide in the litigation setting.

One thing seems clear: Neither Congress nor the states have granted as broad an exemption as many wanted. Without antitrust exemption, hospital providers and others will have to participate in the (health planning) process at risk. Whether their actions will result in antitrust liability, however, or even an antitrust challenge from the enforcement agency, will depend on the same showing of unreasonable restraint of trade that is required in any antitrust litigation.

From an antitrust development standpoint, perhaps the most interesting issue afoot in the health planning arena stems from the stated Congressional intent in the 1979 amendments to preserve and foster competition in health care and urge priority be given to actions which strengthen the effect of competition in allocating the supply of health services. If this goal is to be met, the health planning process itself may give rise to agency consideration of competing applications for a certificate-of-need in a group, not unlike an adminsitrative licensing proceeding. Such proceedings could utilize economic theory in analyzing the effect on competition of particular applications under a rule of reason approach.

Other issues

While I have highlighted three areas for comment, they are only the tip of the antitrust iceberg. In particular, considerably more antitrust litigation can be expected involving the following, but by no means exhaustive, issues:

a. Multi-institution activities, including shared hospital services and departments, and joint purchasing and contracting;

b. Exclusive arrangements between hospitals and hospital-based physician groups, and the somewhat broader issue of denial of hospital staff privileges;

c. Professional accreditation activities, particularly as related to allied health professionals;

d. Prepaid health plan activities — the HMOs;

e. Physician control of third-party plans;

f. Mergers and acquisitions among hospitals;

g. Blue Cross participating vs. non-participating providers;

h. The reasonableness of restrictive third party reimbursement policies aimed at cost containment.

In my opinion, this last area will be the most challenging and mean-

continued on page 478

Put us to the test.

Send us a split specimen—at our expense—we'll prove our accuracy.

First, establish an account with us. It won't cost you anything. Then at your convenience, draw a specimen using accepted procedures. Divide it and submit it under two names. When you receive the results, and you're satisfied they're statistically parallel, call us. We'll credit your account. It's that simple.

What else can you expect?

Quick results. We have three strategically located labs to provide routine test results within 24 hours, tissue results within 48 hours. Plus STAT service on some procedures.

Pickup and mail service. In many areas, our trained couriers will pick up your specimens. Outside our wide service areas, we provide prepaid mailing containers.

Quick-scan highlighted reports. Our reports were designed by pathologists. Abnormals are highlighted, making them easy to spot.

Staff pathologists. Abnormals are reviewed daily by our full-time staff pathologists. Any significant abnormal is immediately retested at no charge and the confirmed results phoned to you. Of course, our pathologists are available for consultation at any time.

Serum retention program. To make it easier for both you and your patient, every serum specimen is frozen for one week after initial testing. If further testing is necessary, just call us.

Accuracy assistance. We can assist you in training your personnel in laboratory procedures and proper specimen handling. Proper collection, handling and submission at your end further ensures accuracy at ours.

We're CBC and we've got a lot more to offer you. Our service is comprehensive, convenient, fast, and most important . . . accurate. Take the time to take our test. It may be one of the best things you ever do for your patients. And we *can* prove it.

To put us to the test call:
1-800-632-0706.

CBC CONTINENTAL
BIO-CLINICAL
LABORATORY SERVICE, INC.
Grand Rapids, Michigan • Toledo, Ohio
Mishawaka, Indiana

U.S. ARMY MEDICAL CAREER OPPORTUNITIES

We are looking for physicians who want to be physicians. We offer a practice that's practically perfect, where you work without worrying whether the patient can pay, without endless insurance forms, malpractice premiums, and cash flow worries, and where you prescribe, not the least care, not the defensive, but the best. If that is what you want, join the physicians who have joined the Army. Write us or call collect for the following information. We can offer:

Specialty Assignments
Residencies
Fellowships
Internships
Health Professions Scholarships
Employment Opportunities

Captain Gerard Indrisano
AMEDD Procurement Office
Federal Bldg.
200 E. Liberty St.
Ann Arbor, Mi 48107
(313) 668-2190

ingful battlefield between health and antitrust policies.

Is there any doubt then that health care issues present challenging opportunities to the antitrust practitioner? The unanswered question is whether health industry litigants, and whether a health provider or a corporation concerned with the skyrocketing of health costs for its employees, will turn to health law attorneys now searching for a Rosetta stone to unlock the secret of Sherman's rule of reason, or will be represented by antitrust practitioners fresh from their cram courses on certificate of need, peer review and relative value schedules.

Conclusion

By way of overall summary of conclusions, the following seem apparent:

1. Almost all defenses that previously had barred antitrust analysis of the health care restrictions have been eroded.

2. More than anything, third-party insurers increasingly will be called upon to mount a full-scale defense to antitrust charges.

3. Courts will continue to be cautious in applying per se approaches to health antitrust cases, at least until the Supreme Court lays down the ground rules. But antitrust violations nonetheless will be established.

4. Antitrust concepts will not be abandoned, or even bent, merely to protect the health care industry. Whatever the attitude at the lower court level, the Supreme Court's (action) suggests stronger, rather than weaker, antitrust pressures on health industry participants.

5. Rule of reason analysis will take into consideration valid, non-collusive efforts to bring about cost containment.

6. Heavier demands will be made for Congressional exemptions in the health field. Those who would seek specific exemptions to reduce antitrust pressures, however, likely are to encounter legislative desire to reduce regulation, and encourage more free market activity, thereby increasing the antitrust pressures on participants.

7. Major corporations as purchaser-consumers of health services for their employees will take a more active role in examining competition-related activities in the field.

Collision course?

We reach the final question then: Are the respective policies of our health and antitrust systems on a collision course? Of course, they are in the sense of one accepted definition of collision: "The *exchange* of force between two objects when they hit." Each has impacted on the other. But to what effect? We are not witnessing an intersection-type collision of an antitrust squad car careening into the side of a health systems ambulance, throwing one or the other out of control, or destroying them both. Rather, what we have seen is a jolt, a "fender-bender" scrape involving both health and antitrust policies. While there may be some dents in the health planning bodies, and some per se headlights of the antitrust car may be temporarily dimmed, both the health industry and the antitrust laws will survive the collision.

The overall legacy of antitrust policy is not being disturbed. Even the judicial hesitancy to condemn restrictive practices by normal application of per se rules is not, in the process, immunizing these activities after full-scale analysis. Nor is the health care system, its present non-competitive warts and all, in danger of being denied needed, though restrictive, cost-containment initiatives simply because the health insurer initiators are put to the test of demonstrating that the restrictions are not unreasonable. The collision, long in coming, is not producing fatalities. In the process, however, it may turn out that the newest and happiest couple on the block may be two of the bystanders at the collision, the health lawyer and his antitrust practitioner companion.

YOUR
INCOME
Employees' Salaries
OFFICE RENT
Utilities

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc. Check these features of the Professional Overhead Expense plan sponsored by the MSMS.

- ☑ **Up to $3,000 monthly benefit**
- ☑ **Waiver of Premium**
- ☑ **Survivors' Benefits**
- ☑ **Professional liability premiums are a covered expense**
- ☑ **Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more**

"we're here to help"

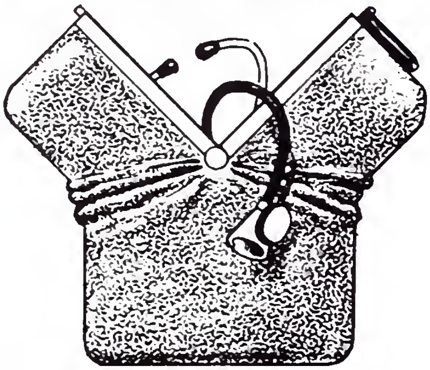
Stratton–Cheeseman & Associates, Inc.
1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823
Call Toll Free: **800-292-1966**

***1979. The National Underwriter Company**

We are all someone's doctor — let's confide about costs

By J. E. McGillicuddy, MD, FACS
Lansing

CO$T
EFFECTIVE
MEDICINE



Blue Pencil sketch

This article is part of a continuing series by MSMS members on medical care cost containment. Members' suggestions are actively sought by the MSMS Task Force on Medical Care Cost Containment, chaired by R. Jack Chase, MD, Grand Rapids.

"Medical care is costing too much!"

From our current vantage point in the eye of the propaganda hurricane a number of observations are possible. To dismiss the outcry as merely serving to define the issues is to be dangerously unaware of the power of an idea whose time seems to have come.

Any representative democracy capable of prohibition is easily capable of national health insurance. This "cost complaint" is a means to an end and the power of the political elements drawn up against us is not inconsequential.

Doctor McGillicuddy is a Lansing family physician.

I would suggest that the strident obliquy from the fourth estate can best be utilized as the clarion call to action.

I am acutely aware of the societal ambivalence that resists any major concerted action on our part in their behalf. But the perception seems to be that every segment and strata of our society is taking in the budgetary belt a notch.

For medicine to "stonewall" for favored status is neither smart nor popular. In our litigious republic, popular is the operative word. Gallup and other relevant polls, including my unofficial one, heavily favor cost containment attempts. The people are often more patient than their representatives.

We are the doctor

In short, business as usual may well be the epitaph to medical practice unencumbered by procrustean bureaucracies and stifling regulation. Now is the time while we have prevailing political winds (I refer the reader to the Kennedy-Corman desuetude).

Dedication and professionalism was not enough in England nor will it be here if the political winds shift. Much is expected of us citizens and after all, "We are the doctor."

The first thing we must do is to gracefully, like parents, accept the responsibility for addressing the problem. Shrill denials merely provide a sounding board for our detractors, whereas the vacuum of a dignified, "We'll take care of it" acceptance will absorb and muffle the restive voices. Americans like to feel someone they trust understands, cares, and is in control.

Our medical association leaders have been assiduously pursuing this course. Through Voluntary Effort, The Commission on the Cost of Medical Care, and myriad state and local medical society committees, have been able, with a few notable exceptions, to avoid faustian commitment. We lack only unity, as always. But it is coming. I know fewer and fewer doctors who believe our correct response should include righteous indignation and aloof isolationism.

Once we have the ball safely on our tee where it belongs, we are, of course, obliged to address it.

I know of hundreds of ways to save a few dollars without gutting our wonderful, flexible, effective, quality based, patient oriented system, and so do you. We all do, and that, thoughtful reader is the point. We are, we ought to, and we will respond. It just takes a while to get going. Which brings us to my final, and if I may, most salient idea.

In a democracy, to work quietly behind the scenes on any subject which has attracted the voter's attention is political suicide. I am speaking not so much of a low key, conciliatory, ongoing media blitz that gently informs the public of the dangers of impatience and counsels regulatory forebearance. I do include, but will not mention, relentless pressure for indispensable changes in our social entitlement legislation that might include copayments, incentives to try to stay healthy, encouraging correct health care system access (especially by those who are on public assistance), and more realism in attempts to legislate a risk-free environment.

Relentless pressure by our considerable lobbying clout is made possible for us at great personal effort and time sacrifice by our leaders in the AMA, national specialty societies and state and local political organizations.

One to one dialogue

More specifically, and I believe most importantly, is the value of daily one-to-one dialogue with our patients. If we are to be ground in the regulatory mill of this democracy we must first be made grist by estrangement from our patients, the public.

Mine is a folksy, friendly reminder that we are all, even the president of the AMA, someone's doctor. Each and every one of us ought to be willing to confide in our patients that we are trying hard to keep the costs down, all the while giving them quality care as long as we have some say in the matter.

They will hear, they will remember, and they are our only chance.

for Knotts in the night
Prescribe new formula
Quinamm*
(quinine sulfate tablets)
each tablet contains quinine sulfate 260 mg

Specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

Merrell Dow

*Trademark of MERRELL-NATIONAL LABORATORIES Inc.,
Cayey, Puerto Rico 00633

Quinamm™

(quinine sulfate tablets)

CAUTION Federal law prohibits dispensing without prescription

BRIEF SUMMARY

INDICATIONS AND USAGE

For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS

Quinamm may cause fetal harm when administered to a pregnant woman Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g) for attempted abortion In about half of these reports the malformation was deafness related to auditory nerve hypoplasia Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys Quinamm is contraindicated in women who are or may become pregnant If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use Recovery usually occurs following withdrawal of the medication and appropriate therapy

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever

WARNINGS

Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision, however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine Quinamm should be stopped immediately if evidence of hemolysis appears

If symptoms occur, drug should be discontinued and supportive measures instituted In case of overdosage, see OVERDOSAGE section of prescribing information

PRECAUTIONS

General

Quinamm should be discontinued if there is any evidence of hypersensitivity (See CONTRAINDICATIONS) Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine (See Drug Interactions)

Drug Interactions

Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

The effects of neuromuscular blocking agents (particularly pancuronium, succinylcholine, and tubocurarine) may be potentiated with quinine, and result in respiratory difficulties

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity

Drug Laboratory Interactions

Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used

Carcinogenesis, Mutagenesis, Impairment of Fertility

A study of quinine sulfate administered in drinking water (0 1%) to rats for periods up to 20 months showed no evidence of neoplastic changes

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test Intraperitoneal injections (0 5 mM kg) were given twice, 24 hours apart Direct *Salmonella typhimurium* tests were negative, when mammalian liver hemogenate was added positive results were found

No information relating to the effect of quinine upon fertility in animal or in man has been found

Pregnancy

Category X See CONTRAINDICATIONS

Nonteratogenic Effects

Because quinine crosses the placenta in humans, the potential for fetal effects is present Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown Quinine in toxic amounts has been associated with abortion Whether this action is always due to direct effect on the uterus is questionable

Nursing Mothers

Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts)

ADVERSE REACTIONS

The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage (Individual or multiple symptoms may represent cinchonism or hypersensitivity)

Hematologic acute hemolysis, thrombocytopenic purpura agranulocytosis, hypoprothrombinemia

CNS visual disturbances, including blurred vision with scotomata photophobia diplopia diminished visual fields, and disturbed color vision tinnitus, deafness, and vertigo, headache, nausea vomiting fever, apprehension restlessness confusion, and syncope

Dermatologic allergic cutaneous rashes (urticarial, the most frequent type of allergic reaction, papular, or scarlatinal), pruritus flushing of the skin sweating occasional edema of the face

Respiratory asthmatic symptoms

Cardiovascular anginal symptoms

Gastrointestinal nausea and vomiting (may be CNS-related) epigastric pain

DRUG ABUSE AND DEPENDENCE

Tolerance abuse or dependence with Quinamm has not been reported

OVERDOSAGE

See prescribing information for a discussion on symptoms and treatment of overdose

DOSAGE AND ADMINISTRATION

1 tablet upon retiring If needed 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring

After several consecutive nights in which recumbency leg cramps do not occur Quinamm may be discontinued in order to determine whether continued therapy is needed

Product Information as of October 1980

Licensor of Merrell*

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

Direct Medical Inquiries to

Merrell

MERRELL DOW PHARMACEUTICALS INC.
Subsidiary of The Dow Chemical Company
Cincinnati, OH 45215, U.S.A.

1-8137 (Y437C)MNQ-699

works well in your office...

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.

- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

The impact of housestaff unionization

By Craig L. Kippels, MBA, Qatar; Deveraux S. Peterson, PhD, Omaha; David R. Barton, MA, Flint.

Housestaff unionization has become an important feature in graduate medical education. Approximately 9,000 of the 60,000 housestaff in the United States already have unionized and efforts toward further organization of housestaff continue in many settings. An understanding of the effects of housestaff unionization is important if institutions are going to cope with this trend.

A group of administrators, residency program directors (teaching chiefs), and housestaff were interviewed to examine their views concerning the effects of housestaff unionization at a 600 bed regional medical center with a recently unionized housestaff. Those interviewed included the administrator in charge of negotiating the first housestaff union contract, the director of labor relations, the staff assistant for medical education, five teaching chiefs and ten housestaff (including the chief of staff and several union officers).

Their responses were organized under the following topics: 1) economic issues, 2) education, 3) housestaff power brokerage, 4) professionalism, and 5) housestaff leadership and militancy.

Mr. Kippels is associate director, Hamad General Hospital, Doha, Qatar. Doctor Peterson is chairman, Department of Dentistry for Children, Creighton University, Omaha. Mr. Barton is director of labor relations, Hurley Medical Center, Flint. At the time this article was written, Mr. Kippels was associate director of Hurley Medical Center and Doctor Peterson was director of residency training in the Department of Dentistry at Hurley Medical Center.

Economic issues

Most administrators felt that the housestaff made modest economic gains, since resident salary and allowances, adjusted for inflation, were not inordinately greater than anticipated increases projected prior to unionization. However, everyone agreed that significant gains had been made in some work conditions. For example, the housestaff received a 25 percent increase in paid time-off. One administrator believed that hospitals might resort to negotiating increased time-off benefits instead of salary increases, since time-off benefits do not cost the institution in actual dollars because housestaff replacements are available at no extra cost.

Institutional efforts toward cost containment probably will be negatively affected by unionization. The administrators and teaching chiefs felt that union participation in some decisions could result in greater costs (e.g., through negotiated purchases of equipment for patient services). Increased time-off for housestaff would decrease clinical income in departments whose patient census is directly related to the amount of time that housestaff are present. Several housestaff mentioned that the union should engage in greater militancy to force greater salary gains for housestaff. Studies have also shown that hospital unions have been able to increase wage differentials between themselves and unorganized groups of similar employees.

Educational issues

The housestaff believed the major educational effect of unionization related to clarification of issues through a contract. These clarifications guaranteed fewer duty hours and that certain rotations would not be withdrawn.

There had been no discernable deterioration in rapport between housestaff and teaching staff. However, the administrators and teaching chiefs believed that housestaff job actions or contract stipulations, which resulted in reduced service commitments, could arouse the antagonisms of some attending staff, since the attending staff would have to fill in for service gaps left by the housestaff.

The teaching chiefs and the administrators believed the major complicating effect on education was the additional amount of negotiated time-off, in the form of vacation, personal days, maternity and paternity leave, etc.; which made scheduling of educational programs more difficult. In fact, it appeared that unionization would have little impact on education in the foreseeable future. Most importantly, the housestaff did not view unionization as a vehicle for intrusion into educational programming or decisions. While they have some power to influence education through job actions or negotiations, it was clear that they desired no deterioration in relations with teaching staff. The courts have also been unsympathetic toward housestaff involvement in educational decisions. For example, the Michigan Supreme Court has limited the scope of bargaining between housestaff and hospitals to employment issues and precluded mandatory bargaining over educational matters. Conflicts over strictly educational issues have also been uncommon at other institutions.

Housestaff as a change agent

A few housestaff indicated that the union should become involved in promoting improvements in patient care and some management decisions. However, it is interesting that the housestaff had not sent representatives to policy-making committee meetings where they had already been granted representational or voting privileges.

The experience at this institution supports the view that quality of patient care and management rights are areas which will not be significantly affected by housestaff unionization in the future. Nevertheless, the fact that housestaff at this institution have not moved into these areas does not necessarily mean that they cannot do so. The housestaff believed that they had the power to force change through the collective power of a group. The teaching chiefs and administrators also felt that the formalization of power links provided the housestaff with direct access into the system.

Professionalism

The housestaff were equally divided in their answers to a question regarding the effect of unionization on professionalism. Those who felt that unionization had an adverse effect on professional behavior believed that participation in a union reduced their status and placed them in the same category as other employees. Those individuals who believed unionization had a favorable effect on professionalism spoke of shared goals of the group and their positive effects on change. It is important to note that no housestaff made reference to how unionization would affect any traditionally important standards of professionalism, such as unselfish service to the patient. The teaching chiefs believed that unionization had the potential to adversely affect the feeling of the importance of the patient over the self interests of the physician and that it could prevent housestaff bargaining individually with teaching chiefs.

Union leadership and militancy

Other areas of concern regarding professionalism related to anxieties over union leadership and fears of strikes. Some housestaff and all the administrators expressed concern that leadership of the union seemed to be dominated by a small group. The administrators also believed a possible danger was radical or militant control. One of the reasons that a small group dominated union activity was that the Foreign Medical Graduates (FMGs) comprised 60 percent of the housestaff membership. Although there was apparently wide support of the union by FMGs, they had been unwilling to accept any active role in the union.

If the lack of FMG participation in union leadership at this institution is characteristic of other settings, it promises to change significantly the effect of housestaff unionization in the future. Legislation has been passed limiting the entry of FMGs into programs in the United States, and this will change the composition of housestaff groups toward proportionately greater United States membership. It probably is safe to say that their participation will not be as passive as the FMGs'.

Several teaching chiefs and all administrators feared that housestaff militism could result in strike threats or actual withholding of services. One administrator said that prior to the housestaff organization he had no fear of a housestaff strike and that that possibility was now a reality. Several of the teaching chiefs and several of the housestaff believed that, during one very tension-laden period in the union contract negotiations, the housestaff could have been persuaded to strike. In fact, one teaching chief and one resident believed that a strike was imminent and would have occurred if quick progress had not been made. The basis for expectations for strikes also can be substantiated by work stoppages in other major health care institutions.

(Bibliography available from the authors.)

Fact:

One out of ten drinkers is an alcoholic.

The important fact to remember is that alcoholism, when properly treated, can be arrested. Our primary goal at Insight is to help people understand and deal effectively with their alcoholism — through intensive, short-term therapy in a residential setting and a planned aftercare program involving families, employers, A.A. and other significant support groups.

For more information, call or write:

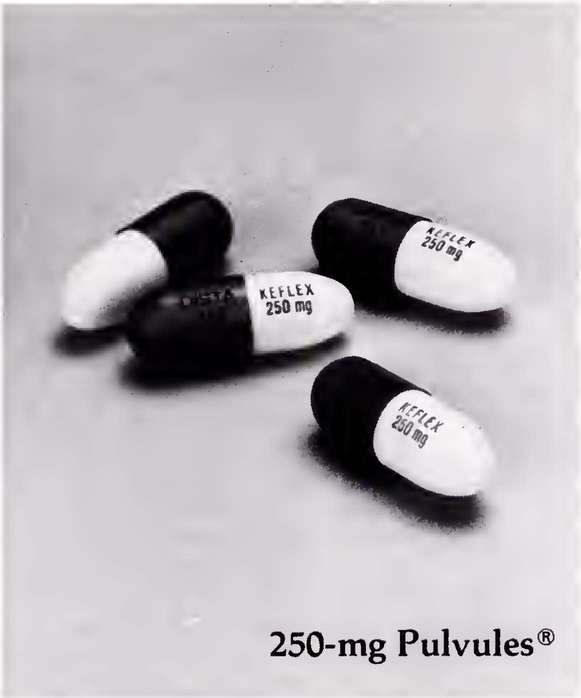
INSIGHT AT COLOMBIERE

9075 BIG LAKE ROAD, POST OFFICE BOX 258
CLARKSTON, MI 48016, TELEPHONE (313) 625-0400

JCAH ACCREDITED

A PROGRAM OF INSIGHT, INC

easy to take



250-mg Pulvules®

Oral Suspension
250 mg/5 ml
100 and 200-ml sizes

125 mg/5 ml
60, 100, and 200-ml sizes

Pediatric Drops
100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Michigan studies of Reye's Syndrome, aspirin, suggest preventive measures available

By William Hall, MD
Lansing

Four cases of Reye's Syndrome have been reported since April 30th. Two cases had onset in April, one in May and one in June. Three of the four cases had a chickenpox prodrome. Two were admitted at stage I, one at stage II and one at stage IV. Since Sept. 1, 1980, a total of 22 cases have occurred in Michigan. None of these children has died.

A preliminary analysis of data collected as a part of the MDPH case-control study was begun this spring. The study was designed specifically to evaluate the hypothesis that medications taken during the antecedent illness might be associated with the development of RS. All 12 case families that were eligible (illness fit the case definition for RS, stage I or greater neurological staging during course of illness, and attending school, nursery school or a day care center where matched controls could be drawn) participated voluntarily. Between one and three matched controls were drawn for each case. Controls were matched on the basis of time of onset and character of antecedent illness, including maximum body temperature, race, school and grade in school. Face-to-face interviews with case and control families were conducted by trained interviewers using a standard questionnaire.

All 12 of the cases versus 13 of 29 of the controls received aspirin or aspirin-containing medications during the prodromal illness (Fishers Exact Test, p = 0.0007). No specific brand of aspirin containing medication was implicated.

The total dosage of aspirin received by RS children ranged from 975 mg. to 25,250 mg (mean 5,487 mg). No relationship was found between the total dosage received and stage of RS on admission or maximum stage reached when adjusted for the weight of the child (total dose/kg) and the weight of the child and length of prodromal illness (total dose/kg/days ill).

The suggestion that aspirin may be a factor in the development of RS is not new.

In 1962, before the disease received its eponym, Mortimer and Lepow reported four infants with varicella, two of whom developed clinical and pathological features compatible with RS. All had taken aspirin.

Other reports also mention the

Doctor Hall is chief, Division of Disease Surveillance, Michigan Department of Public Health.

E. H. ROWLEY COMPANY, INC.
Orthopedic & Prosthetic Appliances

A. Artificial Limbs
B. Commodes
C. Driving Controls
D. Breast Protheses
E. Hospital Beds
F. Lifts
G. Ostomy Supplies
H. Van Lifts
I. Pulsating Mattresses
J. Surgical Garments
K. Trapeze Bars
L. Walkers
M. Wheelchairs
N. Whirlpool Baths
O. Nerve Stimulators
P. Wheelchair Ramps

Please send more information about the circled items:

A B C D E F G H I J K L M N O P

Name ____________________
Address ____________________
City ____________________
State ____________ Zip ________

Tape or glue this Post-Paid Label to any envelope and mail your completed coupon to us. We pay the postage!

No postage necessary if mailed in the United States

BUSINESS REPLY LABEL
First Class Permit No. 9, Royal Oak, MI

POSTAGE WILL BE PAID BY ADDRESSEE

E.H. Rowley Company, Inc.
317 E. Fourth Street
Royal Oak, MI 48067

E. H. ROWLEY COMPANY, INC.
317 E. Fourth St., Royal Oak, MI 48067 Phone: 544-3636
11330 Woodward Ave., Detroit, MI 48202 Phone: 868-6545
G1232 North Ballenger Rd., Flint, MI 48504 Phone: 235-1981
Serving the Handicapped Since 1908

possibility of an association. Linnemann et al analyzed 56 patients with biopsy or autopsy-confirmed disease. Fifty-three had a history of recent salicylate ingestion, and the three others occurred at a time when their epidemiologic study was being conducted only sporadically. Bradford and Parker noted the similarities and differences between RS and salicyclate intoxication and pointed out that the role of salicylates is difficult to determine "because most children with fever are given aspirin." Corey et al found that 136 (78 percent) of 175 patients received aspirin and suggested that this finding was an underestimate. They also state that a case-control study would be necessary to adequately address the potential role of aspirin in RS. Recently, Starko studied seven patients and 16 controls during an outbreak of influenza A. All of the patients and only half of the controls had received aspirin during the prodromal or corresponding illness, but the possibly confounding effect of temperature was not closely examined because of the small number of subjects. The Ohio Department of Health, using a design similar to the ones used in this report, found that 95/98 cases compared with 114/160 controls had received salicylates (p 0.001). The findings of the present study, in which children who developed RS were significantly more likely to have received aspirin-containing medications during the prodromal illness than appropriately matched controls serves, then, to corroborate long-standing suspicions regarding this association.

Viral infection and aspirin ingestion are not the only factors involved in the pathogenesis of RS. Such a hypothesis could not explain the low incidence of the disease relative to the frequency of viral infection, RS's predominantly rural occurrence, its higher incidence in Caucasian children, nor those cases which occur in the presence of good evidence against aspirin usage. We agree with Thaler that multiple factors, including virus, drug, possibly other external toxins, and innate factors (probably involving variations of the urea cycle), are involved in the pathogenesis of RS. However, whereas Thaler suggests that the evidence in favor of the involvement of abnormal ammonia metabolism provides a basis for improving the therapeutic approach, we would stress that the mounting evidence, including information presented in this report, that aspirin is one of the factors in the equation which results in RS, suggests that preventive measures are available.

(This article is taken from the Reye's Syndrome Update No. 13 of the MDPH. References are available from the author.)

MOVING?

Michigan Medicine wants to know

Please notify us a week or two in advance.

CHANGE MY MAILING ADDRESS TO:

Name

Address

City **State** **Zip**

Please paste old mailing label here:

Please send to: Peg Berry, MSMS, P.O. Box 950, East Lansing, MI 48823.

ANNOUNCING THE C.L.I.C.

SPEAKERS BUREAU

Now scheduling PRESENTATIONS on the following investment topics:

- GOLD & SILVER BULLION
- RARE COINS

To schedule a highly enlightening presentation for your next business meeting, contact:

CARLTON LUSH INVESTMENT CORPORATION
Bingham Center • Suite 1646
30700 Telegraph Road • Birmingham, Michigan 48010
(313) 646-8846

Life Members: ANA, CNA, MSNS

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
143 Courtland Avenue
Rockford, Michigan 49341
(616) 866-9395

Microbiological Systems for the Physician's Office

- Troy Biologicals offers a variety of culture systems that enable the physician to perform a culture and sensitivity on different specimens (throat, urine, vaginal, wound, skin, etc.).
- *The Quad Plus System* is an all purpose system which includes a (1) quad plate for identification purposes, (2) a Mueller Hinton plate for sensitivity testing, (3) antibiotic discs, (4) swabs and (5) patient report pads. Pricing for the *Quad Plus System* begins at $1.99 per system. Quantity discounts are available.
- Specialized bi-plate and tri-plate systems are also available for throat and urine specimens. Troy Biologicals also offers a complete line of standard plates and tubed media, such as T.S.A. with 5% sheep's blood, E.M.B. agar, MacConkey agar, etc. Contact us for a price quote.
- A complete set-up is available upon request. Troy Biologicals carries a full line of related microbiological supplies such as incubators, loops, alcohol lamps, swabs, culturettes, disc dispensers, etc.
- A *Workshop in Clinical Microbiology* is also available to those who need additional training.
- Call for a complete price list and colored brochure.

TROY BIOLOGICALS, INC.
6107 E. Ten Mile Road • Warren, Michigan 48091
Call Collect: (313) 759-4530

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN

Healthy Competition Makes A Healthier Market

Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.

Occurrence Coverage

Choice of limits — $100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

MEDICAL NEWSFRONTS

Despite advances in the medical management of kidney transplants, fewer patients now on dialysis can look forward to receiving a donor kidney.

The reason is that an increasing number of prospective kidney recipients have become sensitized to the foreign proteins that are likely to be encountered in a donor kidney, according to a group of investigators headed by Jhoong S. Cheigh, MD, of the New York Hospital-Cornell University Medical College writing in the *Journal of the American Medical Association* (July 10).

The proportion of sensitized patients in their study group grew from 32 percent in 1973 to 92 percent in 1977 before leveling off. Other researchers report a similar incidence of sensitized patients, the authors write.

Two factors may be responsible. First, many patients may have been sensitized to foreign proteins during multiple blood transfusions received in the pre-transplant period. Second, a number of the prospective recipients had already become sensitized from a prior rejected transplant.

The authors report that two investigational procedures, 1) autoimmunization and 2) radiation combined with bone marrow transfusion, hold promise for decreasing the risk of rejection of the kidney graft. In the meantime, they call for protecting kidney recipients from sensitization and for increasing the procurement of cadaver kidneys to improve the chances of matching already sensitized patients with immunologically compatible kidneys.

The widespread availability of high-dose vitamin preparations, which are defined as food supplements and are not regulated by the Food and Drug Administration (FDA), may be helping to nurture a new form of drug abuse — vitamin intoxication.

A group of pediatricians from the University of California Hospital and Clinics, Los Angeles, headed by Barbara Lippe, MD, have described two cases of serious multisystem disease associated with ingestion of excessive amounts of vitamins A and D.

Writing in the *American Journal of Diseases of Children* (July 1981), the physicians noted potentially lethal vitamin A intoxication in two young boys from different families whose parents administered as much and 250,000 units of vitamin A and 4,000 units of vitamin D daily.

On examination, the boys suffered from excess calcium in the blood, signs of increased intracranial pressure, rash, fever, increased sedimentation rate, fluid retention in the face and limbs, bone pain and tenderness, and other symptoms. The boys recovered after hospital treatment.

Four factors contribute to the increased accessiblity and use of high-dose vitamin preparations, called megavitamins, according to the authors: "the frightening combination" of a multimillion-dollar health food industry, an increased emphasis by physicians on more natural approaches to disease treatment, a population of consumers interested in holistic medicine, and a court decision that vitamins are not drugs and may be marketed without FDA control.

This situation has a dangerous potential for abuse of megavitamins and the occurrence of new diseases, the authors warn.

The so-called "Test Tube Baby" approach to enhancing human fertility has been largely a failure and offers small chance to an individual couple of becoming parents.

This is the conclusion of a report from the pregnancy research branch of the National Institute of Child Health and Human Development, National Institute of Health, Bethesda, Md.

At the same time, Gary D. Hodgen, PhD, chief of the branch, reports on promising research with monkeys that offers hope of solving the problem by another approach. The report is in the Aug. 7 *Journal of the American Medical Association*.

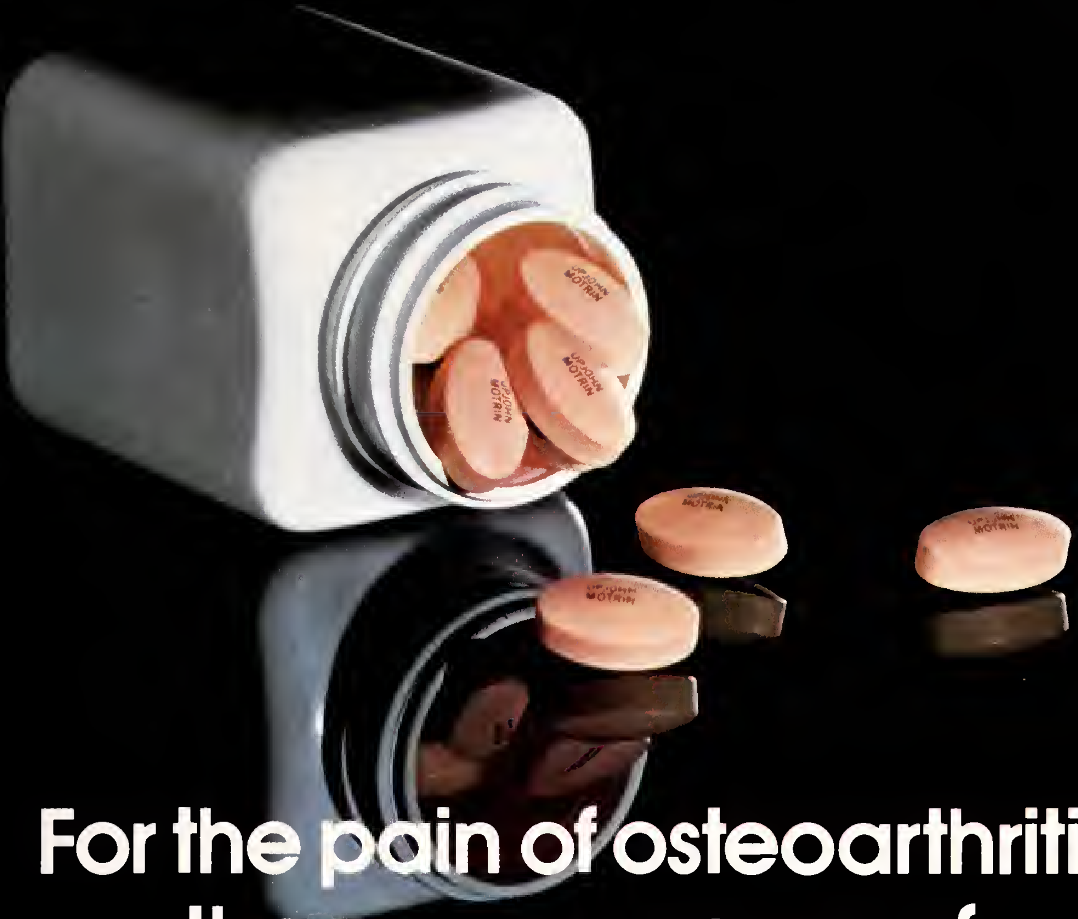
In recent years wide public attention has been focused on fertility experiments in Britain, Australia and the United States. The approach is to remove the egg from the woman who desires to become pregnant but is prevented by blockage of the fallopian tube. The egg is combined in the laboratory with sperm from the father to be. Fertilization results, and the embryo is then transferred to the woman's uterus for continued growth, hopefully leading to normal birth.

The problem is that the rate of successful pregnancies leading to normal births has been so small the Test Tube Baby projects have been largely a disappointment. A scattered few normal births from fertilization outside the mother have been recorded, but the failures have numbered in the hundreds.

Dr. Hodgen reports that the failures are caused by an inherent problem. The embryo fertilized in the test tube grows properly for some 24 hours only, he found. Thereafter the rate of growth slows considerably behind that of normally fertilized embryo. This slower growth rate effectively prevents the normal development of all but a rare few of the implanted embryos.

In the new technique worked out with monkeys, the egg is lifted carefully from its base, moved down past the point of blockage, and left alone. Fertilization then takes place by nature's method, sexual intercourse.

Success ratio with this method parallels natural fertilization from intercourse among individuals with no blockage problems, 16 percent, Doctor Hodgen says.



For the pain of osteoarthritis the proven power of

Motrin®
ibuprofen, Upjohn
600 mg Tablets

One tablet t.i.d.

Please see the following page for a brief summary of prescribing information.

Upjohn

981 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

Motrin® Tablets (ibuprofen, Upjohn)

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin;* use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.
Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.
Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.
Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%) – Probable Causal Relationship
Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

*Incidence Less Than 1% – Probable Causal Relationship***
Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

*Incidence Less Than 1% – Causal Relationship Unknown***
Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship" (PCR)* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Caution: Federal law prohibits dispensing without prescription.

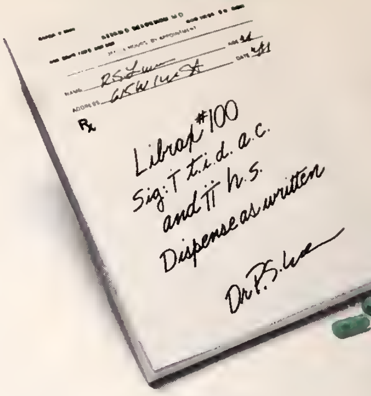
MED B-5-S

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

J-9042-4

July 1981

Specify Librax®


℞
Librax #100
Sig: T t.i.d. a.c.
and TT h.s.
Dispense as written
Dr P.B.

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

> **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows
>
> "Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
>
> Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving) Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated) Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges Syncope reported in a few instances Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy Adverse effects reported with Librax typical of anticholinergic agents, *i e*, dryness of mouth, blurring of vision, urinary hesitancy, constipation Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

ROCHE® Roche Products Inc.
Manati, Puerto Rico 00701

ROCHE®

IN THE G.I. DISORDERS

of Irritable Bowel Syndrome* and Peptic Ulcer*
Librax...the only G.I. medication that provides the action of Librium® (chlordiazepoxide HCl) to relieve the accompanying anxiety found in some patients, plus the action of Quarzan® (clidinium bromide) to reduce colonic spasm and gastric hypersecretion.

Specify

Adjunctive

Librax®

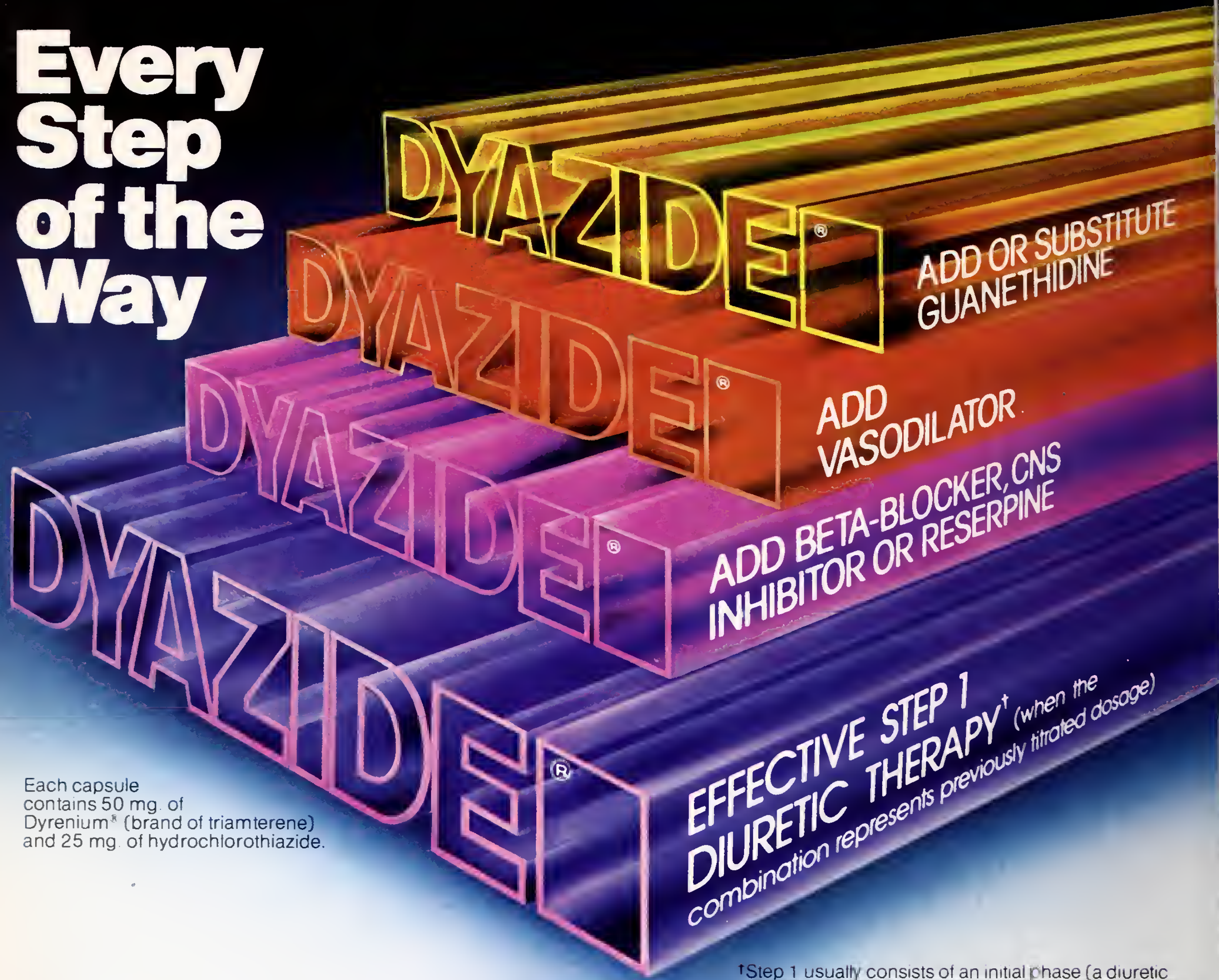
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/ Antispasmodic

*Librax has been evaluated as possibly effective for these indications. Please see summary of prescribing information on facing page.

In Hypertension*...When You Need to Conserve K^+

Every Step of the Way


DYAZIDE®
ADD OR SUBSTITUTE GUANETHIDINE
DYAZIDE®
ADD VASODILATOR
DYAZIDE®
ADD BETA-BLOCKER, CNS INHIBITOR OR RESERPINE
DYAZIDE®
EFFECTIVE STEP 1 DIURETIC THERAPY† (when the combination represents previously titrated dosage)

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently, both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

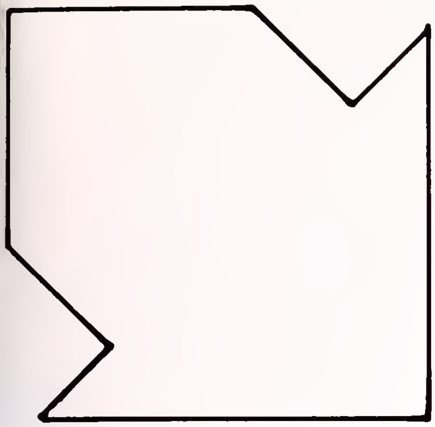
Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

SK&F CO.
a SmithKline company
Carolina, P.R. 00630

NEW MEMBERS



Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Munawar Ahmad, MD P
1314 Sylvan Lane
Midland, 48640

Jagatbhai A. Amin, MD IM/END
11355 Old Goddard Rd. #23
Allen Park, 48101

Epifania A. Aranas, MD PD/NN
Hurley Medical Center
Flint, 48502

Craig N. Bade, MD OBG
291 W. Lakewood Blvd.
Holland, 49423

Pearl C. Beguesse, MD PD
6500 John C. Lodge
Detroit, 48202

Margarett L. Betts, MD IM
15801 McNichols
Detroit, 48235

Bahadur S. Bohra, MD GS/ORS
23290 Outer Drive
Allen Park, 48101

James R. Boswell, DO FP
1560 W. Sherman Blvd. #110
Muskegon, 49444

Francis A. Breen, Jr., MD IM/HEM
1215 E. Michigan
Lansing, 48909

Morris Brown, MD AN/IM
6767 W. Outer Drive
Detroit, 48235

Keith A. Camann, MD IM
4363 Oakwood
Okemos, 48864

John M. Cook, MD OBG
400 Woodward Ave.
Iron Mountain, 49801

Thomas J. Doyle, MD ON/IM
4013 Cedar Run Rd.
Traverse City, 49684

Stanley E. Dudek, MD OTO
1729 E. Saginaw #201
Lansing, 48912

Howard Duncan, MD IM/RHU
2799 W. Grand Blvd.
Detroit, 48202

David B. Edgar, MD IM
21 Michigan St., NE #360
Grand Rapids, 49503

Domingo L. Enriquez, MD P
10238 Trailwood
Plymouth, 48170

Deon F. Faillace, MD GS
3969 Trowbridge
Hamtramck, 48212

Adnan R. Habbal, MD R
18700 Meyers Road
Detroit, 48235

Gwendolyn L. Hoffman, MD EM
21 Michigan, N.E. #170
Grand Rapids, 49503

Stephen F. Hudak, MD DR
Henry Ford Hospital
Detroit, 48202

T. L. Ittiara, MD P
5442 Pineview
Ypsilanti, 48197

Gary L. Johnson, MD FP
Route #2, Box 124-C
Ironwood, 49938

Bruce A. Jones, MD IM
Mill Street Prof. Bldg.
Adrian, 49221

John L. Keller, MD PTH
1616 7th Street
Menominee, 49858

Richard M. Ketai, MD P
2799 W. Grand Blvd. F-1
Detroit, 48202

Kenneth E. Kuper, MD EM
1110 Griswold, S.E.
Grand Rapids, 49507

Saleem Akhtar Malik, MD PS
2799 W. Grand Blvd.
Detroit, 48202

Ernest T. Marshall, Jr., MD OPH
654 Chrysler Dr., #201
Detroit, 48207

Edward A. Matuga, MD OBG
Doctor's Park
Escanaba, 49829

Stewart F. Miller, MD PTH
6642 Cochran Road
Horton, 49246

Lawrence C. Mitchell, MD IM
3910 Springer
Royal Oak, 48033

Angel Ojeda, MD OBG
15921 E. Eight Mile
East Detroit, 48021

John A. O'Sullivan, MD OBG
2310 E. Stadium Blvd.
Ann Arbor, 48104

Thomas Tai Soo Park, MD P
2891 Winter
Troy, 48084

Suzanne R. Parker, MD P
6153 Winan's Lake Drive
Brighton, 48116

Lawrence E. Pawl, MD IM/ON
1001 Medical Park Dr., SE
Grand Rapids, 49506

Jay L. Pearlberg, MD DR
18431 Santa Ann
Lathrup Village, 48076

Linnea J. Priest, MD PD
1514 Benzie Hwy. Box 222
Benzonia, 49616

Chakradhar C. Reddy, MD IM
355 E. Big Beaver Road
Troy, 48098

Charles R. Rouhier, MD FP
2485 Lake-In-The-Woods Blvd.
Ypsilanti, 48197

Jonathan Rosenzweig, MD IM/NEP
2713 Brockman
Ann Arbor, 48104

Sherman D. Sacks, MD OPH
23 N. Hanchett
Coldwater, 49036

Peter T. Savage, MD FP
551 Linn St.
Allegan, 49010

Michael P. Sluss, MD N
154 Bronson Medical Center
Kalamazoo, 49001

Edward J. Snell, MD IM
21 Michigan St., NE #615
Grand Rapids, 49503

Michael Sperl, MD PM
3102 Connecticut
Royal Oak, 48073

The Michigan Doctors Political Action Committee (MDPAC) board members heard Michigan's Lt. Gov. William Brickley, center above, this summer. The Lt. Gov. delivered a special message to the board members on his drive to appoint, rather than elect, Michigan Supreme Court justices, appellate court judges, state board of education members and university board members. With him above are Carl A. Gagliardi, MD, MDPAC Board member, left, and Thomas R. Berglund, MD, former MDPAC Board chairman, now AMPAC board member.

NEW MEMBERS/*continued*

Muhammad Tayyab, MD IM
54 W. Main St.
Milan, 48160

Warren S. Tipton, MD EM
4447 River Road
Toledo, Ohio 43614

Joan K. Vangel, MD IM
6777 W. Maple
West Bloomfield, 48033

Regula Villalobos, MD GP
38207 Townhall Road
Mt. Clemens, 48045

Andrew K. Vine, MD OPH
U-M Dept. of OPH
Ann Arbor, 48109

Robert O. Walker, MD IM
10321 Dartmouth
Oak Park, 48237

Laurence Weber, MD FP
6565 W. Main
Kalamazoo, 49009

Felix Winkler, MD AN
67 Cass Ave. #709
Mt. Clemens, 48043

How to reduce your accounts receivable without lifting a finger.

If your accounts receivable look like the National Debt, don't blame the economy entirely. Your billing system might be part of the problem. Late statements mean late collections. Error-prone or ambiguous statements collect complaints instead of cash.

The Control-o-fax Statement Service eliminates these problems. This service gets your billing out on time every time. And each statement is the exact "picture" copy of your ledger card.

Our Control-o-fax Statement Service clients have reduced their accounts receivable significantly without lifting a finger. Call for full details.

Detroit Area:
Creative Systems, Inc.
18280 W. Ten Mile Rd.
Southfield, MI 48075
(313) 352-9425

Control-o-fax
STATEMENT SERVICE

Outstate Michigan:
Reed Office Systems, Inc.
2883 East Paris Avenue
Grand Rapids, MI 49508
(616) 942-7400
LANSING 482-0200 FLINT 238-7447
TRAVERSE CITY 941-7771
SAGINAW 752-8802

In business communications it takes teamwork to get the job done right!

Effective business communications calls for a tightly knit team that knows communications, knows your business, and knows the importance of reaching your goals as planned and on time. At Michigan Bell we collectively call these specialists the Bell Team. There are many of them . . . each headed by an Account Executive calling the shots, experts in telephone communications and data transmission as well. And equally important, Michigan Bell Account Executives are trained and experienced in the effective application of communications equipment and systems in specific fields: insurance, automotive, banking and many others.

But no Account Executive goes it alone. He or she is backed by a team . . . a staff of industry specialists in the many communications areas . . . who can skillfully execute your plans. So why settle for less when you can call on the skills of the whole team? The Bell Team . . . people who know their business and your business.

Michigan Bell

CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Sept. 14-18, Eighth Annual Family Practice Review. Location: Gordon H. Scott Hall, Wayne State University, Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All interested family physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 DRHUHC, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 40 hours of Category I Credit.

Date: September 18, "A Spore Catcher Looks at Mold Allergies." Location: Sheraton Inn, Southfield. **Sponsor:** Michigan Allergy Society. **For:** All interested physicians. **Cost:** $17. **Contact:** Clyde R. Flory, MD, Secretary, Michigan Allergy Society, 600 S. Capitol, Lansing, 48933, (517) 371-1300. **Approved for:** 1 hour of Category I Credit.

Date: Sept. 18, Renal Disease for the Clinician. Location: Kalamazoo Hilton Inn. **Sponsor:** Michigan Nephrology Center. **Co-Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All primary care physicians. **Contect:** Charles L. Zeller, Jr., MD, Director/CME, SMAHEC, 252 E. Lovell, Room 364, Kalamazoo, 49007. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 17-18, Critical Clinical Issues in the Care of the Elderly. Location: U-M Towsley Center, Ann Arbor. **Sponsor:** U-M Department of Post-graduate Medicine and Health Professions Education. **For:** All interested physicians. **Cost:** $120. **Contact:** Office of CME, Towsley Center, U-M, Ann Arbor, 48109. (313) 764-2287. **Approved for:** 13¼ hours of Category I Credit.

Date: Sept. 23, Second Annual Fall Clinical Day, "Ambulatory Care Medicine." Location: Marshall Civic Center, Marshall, **Sponsor:** Oaklawn Hospital, Marshall and Southwestern Michigan Area Health Education Center. **For:** Primary care physicians. **Cost:** $50. **Contact:** Judith B. Willis, MA, PA-C, Assistant Director/Regional Medical Education, 252 E. Lovell, SMAHEC, Kalamazoo, 49007 (616) 383-7690. **Approved for:** 7 hours of Category I Credit.

Date: Sept. 25-27, Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, and the University of Michigan Medical Center. **For:** All interested physicians. **Contact:** Robert P. Means, Ph.D., Towsley Center for CME, University Medical Center, Ann Arbor, 48109, or phone 313/763-1423. **Approved for:** 16 hours of Category I Credit.

Date: Sept. 28-30, "Nurturing A New Beginning." Location: Kalamazoo Center Hilton Inn. **Sponsor:** Division of Continuing Education, Western Michigan University, Kalamazoo. **For:** OB/GYNs, PEDs, Neonatalogists, FPs, and all others who are concerned about prenatal environment. **Cost:** $35, $65, $75 (for one, two and three days). **Contact:** Div. of Continuing Education, Western Michigan University, Kalamazoo 49008. **Approved for:** 21 hours of Category I Credit.

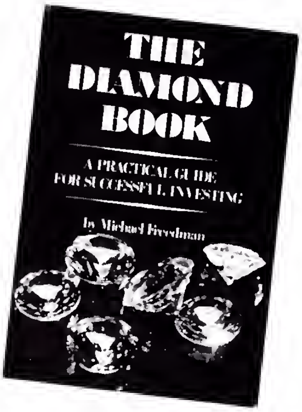
Date: September 30, Advances in Pediatric Hematology-Oncology: Clinical and Laboratory Review. Location: Room 2055, Education and Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: Friday, Oct. 2, 8 am-5 pm, Wednesday, Oct. 28, 1-9 pm, Friday, Dec. 4, 8 am-5 pm. "Gearing Up for Retirement." Location: AMA headquarters, 535 N. Dearborn, Chicago. **Sponsor:** AMA Department of Practice Management. **For:** All interested physicians and spouses. **Cost:** $100. **Contact:** Kimberlee Watts, 312/751-6383. **Approved for:** 4 hours of Category I Credit.

Date: October 3, Immunochemical and Cellular Aspects of a B Cell Immunoproliferative Disorder. Location: Room 2055 — Education & Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All interested physicians. **Contact:** Office of Medical

FREE! To physicians who want to learn about diamond investing — safely and with confidence.

To find out more about diamonds, which have appreciated faster than stocks, gold or silver, send in the coupon. After we meet, I will give you a free copy of this diamond reference book published by Dow Jones-Irwin. It retails for $14.95, but it's yours free in return for your time and interest in meeting with me. CALL (313) 569-2039



ROBERT MONDOR, NATIONAL CONSULTANT
The Diamond Trading Group
24001 Southfield Rd., Southfield, MI 48075

Tape or glue this Post-Paid Label to any envelope and mail your completed coupon to us. We pay the postage!

No postage necessary if mailed in the United States

BUSINESS REPLY LABEL
First Class Permit No. 315 Southfield, MI

POSTAGE WILL BE PAID BY ADDRESSEE

Robert Mondor, National Consultant
The Diamond Trading Group
24001 Southfield Rd.
Southfield, MI 48075

☐ Yes. I'd like to know more about your new diamond investment program. Please call me for an appointment and reserve my free copy of "The Diamond Book".
I understand there is no obligation.

Name (please print)

Address

City State Zip

Home Phone No. Business Phone No.

Education, Henry Ford Hospital, (313) 878-1464. **Approved for:** 7 hours of Category I Credit.

Date: October 3, Edward W. Sparrow Fourth Annual Clinical-Laboratory Update. Location: Edward W. Sparrow Hospital, Lansing. **Sponsor:** Department of Laboratories, Edward W. Sparrow Hospital. **For:** All interested physicians, medical technologists, nurses and students. **Cost:** Physicians, $25; Medical technologists, nurses, residents and fellows, $10; students, no charge. **Contact:** Education Coordinator, Dept. of Laboratories, Edward W. Sparrow Hospital, 1215 E. Michigan Ave., P.O. Box 30480, Lansing, 48909. 517/483-2530. **Approved for:** 3 hours of Category I Credit.

Date: October 3-4, 9th Annual Burns Clinic Medical Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center. **For:** All interested physicians. **Cost:** $120. **Contact:** J.R. Postle, MD, Chairman, Burns Clinic Medical Center, P.C., Petoskey, 49770, (616) 384-4500. **Approved for:** 12 hours of Category I Credit, and 12 prescribed hours by the AAFP.

Date: October 3-4, 9th Annual Medical Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Northern Michigan Hospitals, Inc. **For:** All interested physicians. **Contact:** A. D. Damschroder, MD, Education and Committee Chairman, Northern Michigan Hospitals, Inc., Petoskey. **Approved for:** 12 hours of Category I Credits for two days attendance.

Date: Oct. 8-11, Regional Meeting, Michigan Chapter, American College of Physicians — Michigan Society of Internal Medicine. Location: Boyne Highlands, Harbor Springs. **Sponsor:** American College of Physicians and Michigan Society of Internal Medicine. **For:** All internists and primary care physicians. **Cost:** $30. **Contact:** Boy Frame, MD, FACP, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202. **Approved for:** 21 hours of Category I Credit.

Date: Oct. 11-15, 1982, Abortion: Spontaneous and Induced. Location: Maui Surf Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1011. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-15, 1982, CDS: Contraceptive Delivery Systems. Location: Maui Marriott Hotel, Maui, Hawaii. **Sponsor:** Wayne State University School of Medicine, Department of Gynecology/Obstetrics. **For:** All interested physicians. **Contact:** E.S.E. Hafez, Department of Gynecology/Obstetrics, Wayne State University School of Medicine, 550 E. Canfield, Detroit, 48201. 313/577-1101. **Approved for:** 29 hours of Category I Credit.

Date: Oct. 12-18, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit. **Sponsor:** Wayne State University School of Medicine, Division of Continuing Medical Education. **For:** All full-time emergency medicine physicians. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 9B-32 University Clinics Building, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 35 hours of Category I Credit.

Date: Oct. 12-18, Forensic Pathology: The Investigation of Violent Death. Location: Lansing Hilton Inn. **Sponsor:** MSU School of Criminal Justice. **For:** Medical examiners, coroners and other medical/legal personnel involved in the criminal justice system. **Cost:** $360. **Contact:** Criminal Justice Training, Michigan State University, 580 Baker Hall, East Lansing, 48824 (517/353-5482). **Approved for:** 32 hours of Category I Credit.

Date: Oct. 15-17, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **For:** All interested physicians. **Cost:** $300. **Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, S.E., Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: October 17-18, "Seasons of Life: Alcoholism and Drug Abuse Knows No Age." Location: Grand Hotel, Mackinac Island. **Sponsor:** Michigan Alcohol & Addiction Association. **Accrediting sponsor:** College of Human Medicine, MSU. **For:** All interested physicians. **Contact:** Diana Vella, Administrative Coordinator, Michigan Alcohol & Addiction Association, 23450 Middlebelt, Farmington Hills, 48024. (313) 474-1291. **Approved for:** 10 hours of Category I Credit.

Date: Oct. 28-30, Annual Review: Problems in Internal Medicine. Location: Room 2055, Education & Research Center, Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Cost:** $200. **For:** All interested physicians. **Contact:** Office of Medical Education, Henry Ford Hospital, (313) 876-1464. **Approved for:** 18 hours of Category I Credit.

Date: Oct. 28-30, Blood Coagulation: Clinical and Laboratory Aspects. Location: U-M Towsley Center, Ann Arbor. **Sponsored by:** Medical schools of University of Michigan and Michigan State University. **For:** MDs with major interest in hemostasis. **Cost:** $215. **Contact:** Office of CME, Towsley Center, U-M, Ann Arbor, 48109. (313) 764-2287. **Approved for:** 20 hours of Category I Credit.

Administrative office and main laboratory

AMRC the full service laboratory

- Complete range of individual tests and diagnostic profiles
- Medical consultation services
- Comprehensive quality control program
- Fully accredited
- Complete billing service

Advance Medical &
Research Center, Inc.

1270 Doris Rd • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

NEWS

By Sheri W. Greenhoe
MSMS staff

First recipient of the annual O'Donoghue Sports Injury Research Award is **Thomas R. Peterson, MD,** Ann Arbor. The citation, awarded by the American Orthopaedic Society for Sports Medicine, recognizes outstanding research efforts that can be applied to preventing injuries in sports. ... **Ray Goethe, MD,** is first recipient of the "Bowsher Resident Teaching Award" at Midland Hospital Center. Selected by family practice residents, he has been involved with intern and resident teaching for more than 20 years. ... **Karen S. Johnson, MD,** Michigan State University physician, is recipient of $20,000 National Fund for Medical Education fellowship for research issues among women medical students. Her research on possible conflicts between womens' roles as physicians and mothers or partners begins September at University of Illinois College of Medicine, Chicago. ... **Kenneth Johnson, MD,** Lansing, who delivered three generations of babies, won an unofficial "doctor contest" printed in the July 13 "Onlooker" column of the Lansing *State Journal.* Doctor Johnson is a long time former MSMS officer. ... **Theodore Bauer, MD,** Lansing, and **Perry Spencer, MD,** East Lansing, were cited in the same article for having completed 55 and 50 years of medical practice, respectively. ... First annual Detroit area American Cancer society "life award" recipient is **Vainutis K. Vaitkevicius, MD,** Pleasant Ridge, chief of oncology at Harper-Grace Hospitals. The newly-created citation recognizes metro Detroit medical professionals dedicated to improving quality of survival of cancer patients. ... **Alan D. Perlmutter, MD,** Detroit, was commended by the American Urological Association at its recent Boston Convention for his contributions to continuing education for practicing urologists. ... Detroit-Macomb Hospitals Association President **Jack Ryan, MD,** was appointed treasurer and a member of the Executive Committee of the Michigan Hospital Association Board of Trustees at its annual meeting in June. ... New Upjohn Company Vice President for Medical Affairs is **Alan B. Varley, MD.** ... Clinical associate professor in the University of Michigan School of Medicine's Department of Psychiatry, **Kenneth M. Adams, PhD,** has been appointed head of Henry Ford Hospital's new Division of Neuropsychology within the Department of Psychiatry. ... **S. M. Lindenauer, MD,** chief of staff at the Ann Arbor Veterans Administration Medical Center since 1974, resigned July 1 to devote his time to teaching and research at the U-M Medical School, where he is a professor in the Department of Surgery. ... **Mitchell A. Kaminski, MD,** Kalamazoo, was one of 20 family practice residents named recipients of the 1981 Mead Johnson Awards for Graduate Education in Family Practice. ... **Bernard H. Marks, MD,** Grosse Pointe Woods, is new chairman of the National Board of Medical Examiners Part I Pharmacology Test Committee. ... U-M scientist **C. William Castor, MD,** was awarded The Geigy International Rheumatism Prize, one of the highest international honors given for achievement in the field of rheumatic disease. Presented every four years, the prize recognizes outstanding work. Doctor Castor was cited for his discovery of a family of "signal proteins" which regulate the metabolism of connective tissues.

The Michigan Foundation for Medical and Health Education met this summer to authorize annual grants to Michigan's three medical schools. The grants will be based on this fall's medical school enrollments. Officers at the board meeting are, from left, Treasurer B. James "Ted" Theodoroff, Bloomfield Hills; President Harry A. Towsley, MD, Ann Arbor; Secretary Warren F. Tryloff, East Lansing, and board member Elmer White, Okemos.

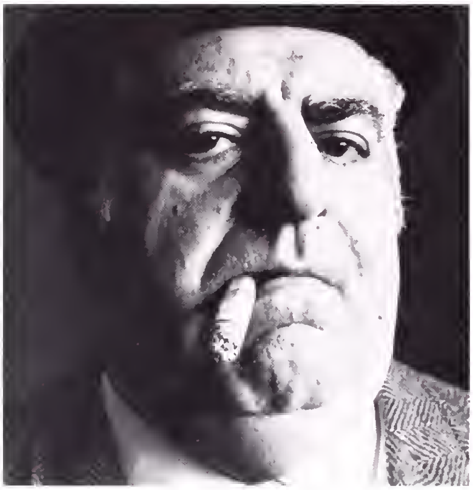
South Macomb Internists, P.C.
is pleased to announce
the establishment of
South Macomb Thyroidology
under the direction of

DAVID L. THOMSON, M.D.
(Diplomate ABIM-certified
Endocrinology and Metabolism)
Available Services Will Include:

PHYSICIAN ASSESSMENT
RADIONUCLIDE IMAGING
RADIOACTIVE IODINE THERAPY
THYROID FUNCTION TESTING

11012 E. 13 Mile Road
Warren, Michigan 48093
Telephone (313) 751-7171

THE ART
OF OWING MONEY...



"PAY THE
DOCTOR/DENTIST LAST."

Consumer magazines are advising people with financial problems to pay their doctors and dentists last...if at all. But now you have help – I.C. Systems – an effective and ethical system for collecting delinquent accounts. A nationwide collection service, I.C. is approved by your association. Mail this coupon today to learn more...

The System
Works IC

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ________________
Address ________________
City ________________
State ____________ Zip ________
Signature ________________

NME can set up the practice you want.

In the area you want.

It's a goal we achieve by offering you a choice of over 60 well equipped acute care hospitals coast to coast; by offering you selected financial assistance, and by offering you management consulting when you begin your practice.

At National Medical Enterprises, we'll help you establish a comfortable and successful Primary Care practice.

Where you want it.

How you want it.

So whether you're interested in a solo, partnership, or a group practice, you should contact NME.

We're the experts.

For further information, contact:
Raymond C. Pruitt, Director Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.
Call Toll-Free 800-421-7470
or collect (213) 479-5526.

NATIONAL MEDICAL ENTERPRISES, INC. NME

"The Total Health Care Company."
An Equal Opportunity Employer M/F

PHYSICIANS

ASSISTANT DIRECTOR
ASSOCIATE DIRECTOR

Ann Arbor, Michigan

Warner-Lambert is a leading worldwide developer and marketer of health care and consumer products, including prescription and proprietary pharmaceuticals, dignostic and hospital products, scientific instruments, confectionery and specialty foods. Our Parke-Davis, Pharmaceutical Research Division has excellent opportunities available to join the Clinical Research staff at the Assistant or Associate Director level.

These positions require:

- An M.D. degree with board certification or board eligibility in one or more of the following specialties: cardiology, oncology, anti-infectives, pulmonary diseases or interal medicine with significant experience in one of the above fields.
- 3 or more years of medical practice experience
- Background in clinical research and clinical pharmacology desirable
- Outstanding written and oral communication skills

Responsibilities include:

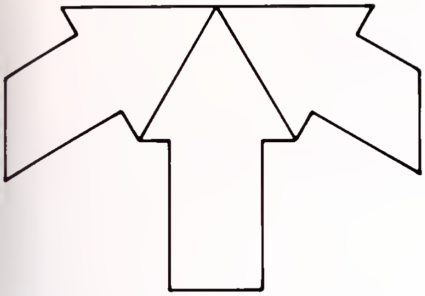
- Planning and implementation of clinical drug programs including protocol design and liaison with field investigators
- Preparation of reports for FDA submission
- Participation, along with preclinical research scientists, in the evaluation of new research avenues for the above theraputic areas

Warner-Lambert offers an attractive compensation package including competitive salary, bonus, stock option plan, malpractice coverage, and three weeks vacation. In addition, our modern research facility is located next to the University of Michigan campus in Ann Arbor, MI - an area which offers excellent recreational and cultural opportunities. Interested and qualified candidates should forward resume/curriculum vitae with salary history in confidence to: **Ms. D. Love, WARNER-LAMBERT/PARKE-DAVIS, Pharmaceutical Research Division, 2800 Plymouth Rd., Ann Arbor, Michigan, 48105**

An Equal Opportunity Employer M/F/H

WARNER LAMBERT

MEETINGS



MSMS, MSMS/A, AMA and medical assistants

Oct. 21 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Oct. 21-22 — Fall Leadership Conference, MSMS Auxiliary, Lansing Hilton Inn, contact: Caroline Rich at MSMS headquarters.

Oct. 22 — Annual MSMS Public Affairs/Leadership Conference, Lansing Hilton Inn, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Oct. 30-31 — AMA Fifth National Conference on Medical Care and Health Services in Correctional Institutions, Marriott Hotel, Chicago, contact: AMA Department of Correctional Activities, 535 N. Dearborn Street, Chicago, 60610.

Nov. 3-4 — Diet & Exercise: Synergism in Health Maintenance, sponsored by the AMA, Walt Disney World Complex, Florida, contact: AMA Department of Foods and Nutrition, 535 N. Dearborn St., Chicago, 60610.

Nov. 4 — MSMS 1981 Health Issues Conference, "Stress in the Contemporary Woman," Long's Convention Center, contact: Sherry Wellman, MSMS headquarters.

Nov. 7-8 — Fall Seminar, State of Michigan Branch, American Association of Medical Assistants, Holiday Inn, Battle Creek, contact: Caroline Rich, MSMS headquarters.

Nov. 17-19 — 1981 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Feb. 6-13 — MSMS/INTRAV West Indies Air/Sea Cruise, contact: Marce Ireland, MSMS headquarters. 517/337-1351.

Other meetings:

Sept. 22-26 — American Medical Writers Association 41st Annual Conference, Prince Hotel, Toronto, contact: AMWA, 5272 River Rd., Suite 370, Bethesda, MD, 20016.

Oct. 1 — Michigan Psychiatric Society Council Meeting, Recess Club, Detroit, contact: Helen Schulte, MSMS headquarters.

Dec. 3 — Michigan Psychiatric Society Council Meeting, Recess Club, Detroit, contact: Helen Schulte, MSMS headquarters.

Dec. 5 — Eleventh Annual Workshop, Michigan Speech Pathologists in Clinical Practice (MSPCP), Detroit Athletic Club, contact: Christine Sowinski, Oakwood Hospital Audiology & Speech Pathology Dept., 18101 Oakwood Blvd., Dearborn, 48124, or 313/336-3000, ext. 517.

Michigan court rules on privacy rights, adoption, surrogate mother

The Michigan Court of Appeals has upheld the argument of Attorney General Frank J. Kelley that the Michigan Adoption Code does not infringe on personal liberties or the right to privacy by prohibiting payment to a woman in exchange for bearing, and delivering a child for subsequent adoption of the biological father.

The decision was rendered in the case of a married couple living in Wayne County who wanted to pay another woman $5,000 plus expenses to artificially conceive, bear and deliver a child for subsequent adoption by the married couple. The Attorney General argued the case on behalf of Wayne County Prosecutor William Cahalan.

The case was appealed from Wayne County Circuit Court on behalf of Jane and John Doe (pseudonyms for the married couple) who wanted to hire Mary Roe (a pseudonym for a woman who worked as a secretary for John Doe) to conceive a child through medically-supervised artificial insemination.

Their agreement — which was prohibited by the Michigan Adoption Code — called for John Doe's signing necessary papers acknowledging paternity and Mary Roe's consenting to adoption by the biological father and his spouse. In addition to receiving $5,000, Mary Roe was to receive medical expenses and was to be covered by sick leave, disability and medical insurance while she was off work having the baby and recuperating.

Attorneys for John and Jane Doe argued that the prohibition within the Michigan Adoption Code infringed on their constitutional right to privacy.

While acknowledging the plaintiff's right to privacy in the decision to bear or beget a child, the Court of Appeals agreed with the Attorney General in saying:

"The statute in question does not directly prohibit John Doe and Mary Roe from having a child as planned. It acts instead to preclude plaintiffs from paying consideration in conjunction with their use of the state's adoption procedures. In effect, the plaintiffs' contractual agreement discloses a desire to use the adoption code to change the legal status of the child — i.e., its right to support, intestate succession, etc. We do not perceive this goal as within the realm of fundamental interests protected by the right to privacy from reasonable governmental regulation."

Arnold O. Abraham, MD
Jackson

Arnold O. Abraham, MD, Jackson died July 19 at the age of 77. He received his MD degree from the University of Cincinnati Medical School in 1930. Doctor Abraham retired from his private practice in 1970 to join Jackson's Foote Hospital staff. He served as president of the Lenawee County Medical Society in 1965.

Napier Aldrich, MD
Detroit

Napier Aldrich MD, Detroit, died June 25. He was 78. Doctor Aldrich received his MD from the University of Michigan Medical School in 1928. He maintained a private practice in Coldwater until his retirement in 1972. During World World II he served as a U.S. Coast Guard physician. He also was the former chief of staff of the Branch County Community Health Center.

Reuben Alexander, MD
Laingsburg

Reuben Alexander, MD, of Laingsburg, died July 8 at the age of 82. He received his MD from the University of Michigan Medical School in 1935, and graduated from the Willis Eye Hospital in 1946. Doctor Alexander retired from his private ophthalmology practice in 1970.

David A. Amos, MD
Muskegon

David A. Amos, MD, died June 30 at the age of 45 in a Lake Michigan plane crash. He was chief of staff at Muskegon Mercy Hospital. Doctor Amos received his MD from the University of Michigan Medical School in 1961, then served as a US Army physician from 1962 to 1964. He completed post-graduate work at the Mayo Clinic in 1967.

Guido A. Annessa, MD
Muskegon

Guido A. Annessa, MD, died June 30 in a Lake Michigan plane crash. He was 53. Doctor Annessa was the former chief of staff at Muskegon Mercy Hospital. He received his MD from the Wayne State University

continued on page 506

STAFF PHYSICIAN

Family Practitioner or Internist Full Time Position
At Kent Community Hospital, A Community Based
Chronic Disease and Rehabilitation Center.

KENT
COMMUNITY
HOSPITAL COMPLEX

For Further Information Contact:
Kent Community Hospital
Executive Director
750 Fuller, N.E.
Grand Rapids, MI 49503
Phone (616) 774-3361

Self-insurance saves you money, but it needs the care of a money manager.

Many hospitals have found significant savings in self-insuring their malpractice coverage. In fact, in-hospital coverage of workmen's compensation and other employee benefit programs such as dental, health, disability and group life insurance has dramatically increased the use of self-insurance in medical institutions.

Proper administration of a self-insurance program, however, needs the services of an experienced investment manager, Detroit Bank & Trust.

We've served Michigan residents for over 130 years and rank as one of the largest trust institutions in the midwest. Our outstanding record as a manager of fixed income securities and our extensive experience in administering employee benefit programs have led many hospitals to choose us as their investment manager for self-insurance plans.

If you would like more information on how we can help you with your self-insurance or employee benefit programs, call or write Terry Keating, Vice President, at (313) 222-3898, Detroit Bank & Trust, Box 59, Detroit, Michigan 48232.

Self-insurance is not your most important job, but managing your money better is ours.

DETROIT
BANK
& TRUST

Member FDIC

Principal Trust Offices in
Detroit • Birmingham • Gaylord

Mr. Terrence E. Keating, Vice President
Detroit Bank & Trust
Post Office Box 59
Detroit, MI 48232

Please contact us in regard to administering our self-insurance program.

Name________________ Title____________

Hospital________________________

Address________________________

City____________ State________ Zip________

Telephone________________

School of Medicine in 1958, and completed post-graduate work at St. Joseph Mercy Hospital and Detroit Receiving Hospital. Doctor Annessa was a member of the Detroit Surgical Association and Phi Rho Sigma medical fraternity.

Meyer S. Ascher, MD
Detroit

Meyer S. Ascher, MD, Detroit, died July 21 at the age of 75. He was a Detroit allergist for more than 50 years, and recently received a Golden Anniversary Diploma from the Wayne State University Alumni Association. Doctor Ascher served as a naval commander in WW II.

Edward J. Buttrum, MD
Farmington Hills

Edward J. Buttrum, MD, Farmington Hills, died June 28 at the age of 71. He received his MD from the Wayne State University School of Medicine in 1935. Doctor Buttrum, a surgeon, was on the staff at Grace Hospital's Northwest Unit in Detroit. He was a member of Phi Beti Pi medical fraternity.

Malcolm D. Campbell, MD
Miami, Florida

Malcolm D. Campbell, MD, former Detroit ophthalmologist, died May 25. He was 80. He was an assistant professor of Ophthalmology at Bascom Palmer Eye Institute of Miami. Doctor Campbell received his MD from the University of Western Ontario Medical School. He was a member of the American Academy of Ophthalmology and Otolaryngology for 57 years, and was a fellow of the American College of Surgeons. Doctor Campbell practiced in the Detroit area for over 40 years.

Walter S. Dailey, MD
Niles

Walter S. Dailey, MD, Niles, died June 2 at the age of 53. He received his MD from McGill University, Quebec, in 1958. Doctor Dailey was on the staff of Pawating Hospital in Niles. He was an associate member of the American Society of Medical Hypnosis, and of the American Academy of General Practice.

Jack R. Greenburg, MD
Detroit

Jack R. Greenburg, MD, Detroit, died July 7, at the age of 70. Doctor Greenberg was the director of Mt. Carmel Mercy Hospital's family practice program, which he co-founded in 1978. He received his MD degree from the Wayne State University School of Medicine in 1938. Doctor Greenburg was a member of the National Board of Certified Family Practice Medicine, and past president of the Zionist Organization of America.

Azizolah Malakuti, MD
Birmingham

Azizolah Malakuti, MD, died July 25 of gunshot wounds inflicted by a patient. He was 49. Doctor Malakuti received his MD from the University of Teheran School of Medicine in 1960. He was director of the Pre- and Aftercare Clinic of the North Oakland Community Mental Health Board, Pontiac. Doctor Malakuti was affiliated with Pontiac State Hospital. He was a member of the American Psychiatric Association and the American Society of Clinical Hypnosis.

Edwin R. McKnight, MD
Owosso

Edwin R. McKnight, MD, Owosso, died July 9 at the age of 75. He received his MD from the University of Michigan Medical School in 1935. Doctor McKnight delivered more than 7,000 babies during his practice, from which he recently retired. He served in the U.S. Army from 1942 until 1946, and received a Purple Heart in the WW II European Theater.

Benjamin T. Montgomery, MD
Sault Ste. Marie

Benjamin T. Montgomery, MD, Sault Ste. Marie, died July 2 at the age of 85. He received his MD from the Wayne State University School of Medicine in 1924, and was the former chief of surgery at Detroit Receiving Hospital. Doctor Montgomery was a past member of the MSMS House of Delegates, was past president of the Chippewa-Mackinac County Medical Society, and was former chief of staff at War Memorial Hospital. He retired from his private practice in 1966.

Dave B. Ruskin, MD
Boca Raton, Florida

Dave B. Ruskin, MD, formerly Saginaw, died June 27 at the age 74. He was past president of th Michigan Psychiatric Society. Doct Ruskin received his MD degree fro the University of Ontario Medic School in 1933. He was honored i 1962 for his outstanding service i instituting a curriculum for gener practitioners in psychiatry and in r cruiting faculty in the Kalamazo and Saginaw areas. He had been r tired for nine years. Doctor Ruski was a member of the American Ps chiatric Association, the Michiga Society of Neurology and Psychiatr and the American League again Epilepsy.

Arthur J. Seaborn, MD
Southfield

Arthur J. Seaborn, MD, died July 6 the age of 79. He received his M from the Wayne State Universit School of Medicine in 1927. Docto Seaborn practiced at the Mt. Carm Mercy Hospital obstetrical depar ment for 25 years. He was a membe of Phi Rho Sigma medical fraternity.

Karl Stillwater, MD
Detroit

Karl Stillwater, MD, Detroit, die May 30 at the age of 59. He receive his MD from the University of In diana Medical School in 1945. H was affiliated with Childrens, Grace Sinai and Crittendon General hospi tals of Detroit. He was a member o the Detroit Pediatric Society, Alph Omega Alpha, and Phi Delta Epsilo medical fraternities.

Maurice B. Weiner, MD
Southfield

Maurice B. Weiner, MD, Southfiel died July 24 at the age of 77. He re ceived his MD from the University o Michigan Medical School in 1928 He was on the staff of Detroit's Mt Carmel Mercy, Childrens and Sina hospitals. He was a member of th Detroit Pediatric Society, the Ameri can Academy of Pediatricians, an Phi Lambda Kappa medical frater nity.

Patients needed or these U-M studies

Chronic suppression of adrenal function with op 'DDD in Cushing's Disease

he purpose of this study is to evaluate: 1) The use of Mitotane
p'DDD) in combination with cobalt irradiation to the pituitary
land as primary treatment for Cushing's disease; 2) Once clini-
al and biochemical remission of Cushing's syndome has oc-
urred, the duration of remission, incidence of recurrence and
evelopment of Nelson's syndrome; 3) Toxicity associated with
ng-term Mitotane administration; and 4) Mechanism of action
f Mitotane (adrenocortical suppression vs. suppression of
CTH secretion).

Patients with pituitary ACTH-dependent Cushing's syn-
rome are being admitted to this protocol for initial evaluation of
ypothalamic pituitary adrenal function.

Patients are also evaluated for the presence of a pituitary
icroadenoma. Patients who are not surgical candidates for
ransphenoidal pituitary exploration receive treatment with
obalt irradiation of the pituitary gland and Mitotane, in doses of
-6 gm daily. Maintenance doses are usually 1-2 gm daily. Pa-
ients are readmitted at three to four month intervals for the fol-
wing studies: a) Baseline pituitary adrenal function; b) Adrenal
esponse to exogenous ACTH; c) Measurement of biochemical
dices possibly effected by Mitotane (laboratory test panel, lipid
vels, CBC); d) Measurement of blood levels of Mitotane.

Treatment of severe psoriasis with Vitamin A derivatives retinoids).

atients with severe psoriasis (greater than 20 percent of their
ody surface area involved with psoriasis) or patients with dis-
bling psoriasis are being treated with etretinate, an experimen-
l derivative of Vitamin A. This oral therapy has been effective
90 percent of our patients in a preliminary study. The current
tudy focuses on clinical changes, alterations in immunity, and
creases in serum lipids which may occur during etretinate
erapy. Because of the known teratogenesis, women of child-
earing potential are excluded from this study. There is no
harge to patients who are accepted for participation in this ex-
erimental protocol.

ACTH and beta-endorphin secretion in obesity

CTH and beta-endorphin have been found to be elevated in
enetically obese (ob/ob) mice and (Fa/Fa) rats. It has been
uggested that beta-endorphin could be responsible for hyper-
hagia and obesity in these animals. Beta-endorphin is also ele-
ated in obese hirsute women. The present study is aimed at
etermining if: 1) ACTH and beta-endorphin secretion is exces-
ive in obese humans; 2) Abnormal beta-endorphin release is
haracteristic of a specific type of obesity (childhood vs adult-
nset), and 3) Abnormal beta-endorphin release is associated
vith some of the hormonal and metabolic complications of obes-
y, namely, abnormal insulin and glucose levels and excessive
ndrogen secretion. Serial plasma ACTH, cortisol and beta-
ndorphin levels are being determined in two subsets of obese
atients, the childhood and adult-onset types, following the ad-
ninistration of: a) Insulin and b) Metyrapone. The pattern of
eta-endorphin release in obese people will be correlated with
asal and stimulated insulin and glucose levels as measured in
he performance of an oral glucose tolerance test.

The study protocol involves the performance of an oral glu-
ose tolerance test and a pituitary function test on an outpatient
asis and a Metyrapone test obtained over a three day period in
he inpatient Clinical Research Center.

For futher information in all three studies please contact Irving H. Fox, MD, Director, Clinical Research Center, University Hospital, Ann Arbor, 48109.

INSTANT CURES?

PR
DATE
NAME
℞

Sometimes there are.

The doctor may not have a bag full of instant cures, but we just might have some instant cures for the doctor. For instance, if your retirement program is an insured plan, we can show you how to cut costs *instantly* by changing to a trusteed plan. We're Watkins, Ross, Baines and Lamps, with some instant cures for problems confronting retirement programs. At WRB&L, we design all types of retirement plans for professional corporations. Once a plan is implemented, our services can provide you with the required actuarial reporting, while we monitor and periodically reevaluate the effectiveness of your program. We're one of the largest actuarial firms in the Midwest and work on an hourly basis.

Sometimes there are instant cures, at least when it comes to retirement planning for professional corporations. Call us. It's just what the doctors order.

WR
B&L

WATKINS/ROSS/BAINES & LAMPS, INC./Consultants and Actuaries
505 Waters Bldg./Grand Rapids, MI 49503/Phone (616) 456-9696
400 Renaissance Ct./Suite 500/Detroit, MI 48243/Phone (313) 568-2222

Doctor Potchen on AMA committee studying medicine's, nursing's roles

By Charles R. Downs, special to Michigan Medicine

A grey fog seems to obscure the boundaries dividing the territory of medicine from the territory of nursing. And it may take a lot of sunlight and perhaps a fair amount of committee-generated wind from both sides of the border to disperse the fog, to survey the boundaries and to establish appropriate markers.

That activity has to happen at the national level and also at the state level, as some situations vary from state to state, says James E. Potchen, MD, chairperson of the Department of Radiology at Michigan State University and a member of the AMA Council on Education.

It was in the latter position that Doctor Potchen recently served as a member of an AMA intercouncil committee studying the role of physicians assistants (PAs). In the course of the study, the committee also looked at nurse practitioners who, in effect, are serving as PAs because they are working directly under physicians.

The committee's report is under review at AMA headquarters. Meanwhile, a joint committee representing the AMA Board of Trustees and the American Nursing Association leaders also is trying to reach consensus on the issues.

PAs, nurses

Doctor Potchen contends that nurses have a legitimate area of practice apart from, but overlapping in some areas, medical practice. However, he adds, there is not a PA practice as such because PAs function within medical practice.

"It is proper," he says, "for a nurse to practice nursing. But if she/he is actually practicing nursing under the authority of a physician, he/she should be licensed as a physician assistant.

He also argues that nurse practitioners should be licensed by state nursing boards, not by medical boards, as physician assistants normally are.

"We need policy and ethic guidelines for the border areas between nursing and medicine," he says. "The nursing profession should be independent and autonomous. But if nurses function as PAs — as they often do — then they should be subject to the boundaries established for PAs."

Doctor Potchen thinks ethical issues arise when a physician sets a nurse up in an office, perhaps even separate from his main office, to practice primary medical care.

"If the physician profits from this kind of arrangement, that is a problem," Doctor Potchen contends.

"We need ethical standards for this kind of situation, particularly in rural areas where there is a greater potential for exploitation.

"There is no problem if nurses in such situations follow the PA guidelines," continued Doctor Potchen. But he understands nurses don't want to do that because they want to be independent.

Define rules

"That's fair. There certainly is a case for an independent, autonomous profession of nursing," says Doctor Potchen. "But when nurses function as physicians, the rules should be clearly defined and not too different from the rules that PAs operate under."

Doctor Potchen says the number of nurses aiming for nurse practitioner status may be too large at a time where there is a severe shortage of nurses in hospitals. This shortage, he argues, is due to lack of pay commensurate with their educational levels and experience.

Doctor Potchen contends that the ANA's coming move to require that all nurses have at least a bachelor's degree as a minimum educational requirement is not necessary, when there are such a large number of nurses needed in hospital posts. Hospital nursing, he believes, is performed at a level which requires special skills and training rather th
the broader kind of knowledge rep
sented by a bachelor's program.

"We need more available me
cal care but we do not need m
neurosurgeons in Boston," he poi
out. "Similarly, we need more nur
to carry out a variety of functions,
all of which require a four-year c
lege education."

Thanks to our advertisers

Advanced Medical Research	4
Brown Pharmaceutical	4
Burroughs-Wellcome	4
Carlton Lush Investment	4
CBC Lab	4
Detroit Bank and Trust	5
Diamond Trading Group	4
E. H. Rowley Co.	4
Eli Lilly	4
I. C. Systems	5
Insight at Colombiere	4
Kent Community Hospital	5
Medical Protective	4
Merrell-Dow	4
Michigan Bell	4
Michigan Physicians Mutual Liability Company	4
MSMS Annual Scientific Meeting	I
National Medical Enterprises	5
Physicians Insurance Company of Michigan	4
Reed Office Systems	4
Roche Laboratories	458, 4 460, 492, 4
Smith, Kline & French	4
South Macomb Thyroidology	5
Stratton-Cheeseman	4
Troy Biologicals	4
Upjohn	491, 4
U.S. Army	4
Warner-Lambert/Parke Davis	5
Watkins, Ross, Baines & Lamps	5
Wyeth Labs	471, 4

LASSIFIED

e rate for each classified ad-
rtisement in *Michigan Medicine* is
¢ per word, with a minimum
arge of $7.50. Copy for classified
vertisements should be received
t later than the first of the month
eceding the month of publication.

ositions open

IZONA EMERGENCY MEDICINE: Director-
p and clinical positions available for
eer-oriented emergency physicians in
ny western Arizona resort town. Excellent
ome, paid professional liability insurance,
flexible scheduling without on-call duties.
details call Lillian Asato toll-free, 1-800-
-6655; or send credentials in confidence to
Wilshire Boulevardn Suite 504, Santa
nica, CA 90401.

ERGENCY MEDICAL POSITIONS — Emer-
cy Consultants, Inc. has Emergency Medi-
e opportunities available in resort and met-
olitan locations. 60 hospitals in 12 states
currently serviced. Benefits include com-
itive salaries, paid malpractice insurance,
flexible scheduling. For further informa-
contact: Emergency Consultants, Inc., 2240
th Airport Road, Suite 115, Traverse City,
49684; 1-800-253-1795 or in Michigan
00-632-3496.

NTED: Board Certified or Eligible Or-
paedic Surgeon specializing in hand recon-
ction to join 2-man orthopaedic group in
higan. Unique cultural and educational
nmunity of approximately 65,000. Salary
s excellent benefits. Send curriculum vitae
Box 22, Michigan State Medical Society,
W. Saginaw, East Lansing, MI 48823.

YSICIAN WANTED to serve as Medical Di-
tor of Hospice in Lansing. Quarter-time ad-
istrative position. Responsibilities include
rdination of team meetings, training and
ervision of staff physicians, and supervi-
n of medical care in consultation with pri-
ry physicians. Must be willing to participate
a schedule of on-call coverage with other
ff physicians. Should have palliative care
ls, be oriented to Hospice care principles,
able to work in multidisciplinary team set-
. Resumes to: Hospice of Lansing, 800 Ab-
t Road, East Lansing, MI 48823 (517) 332-
l7.

OUP HEALTH PLAN, a 24-year old, 140
sician, prepaid multi-specialty group with
lve clinics in the Minneapolis/Saint Paul
a seeks board eligible or board certified as-
iates in INTERNAL MEDICINE, ENDOCRI-
LOGY, GASTROENTEROLOGY, OTOLAR-
GOLOGY, OPHTHALMOLOGY, ORTHO-
DIC SURGERY, PEDIATRICS, and FAMILY
ACTICE. Positions available for 1981 and
2. Send CV to: Paul Brat, MD, Group Health
n, 2500 Como Avenue, Saint Paul, Min-
ota 55108. An equal opportunity employer.

HTHALMOLOGIST WANTED to do office
thalmology two or three days a week in
l-equipped suburban office outside of De-
t. Excellent terms. Reply to Box 19, Michi-
State Medical Society, 120 W. Saginaw,
t Lansing, 48823.

HTHALMOLOGIST FULL-TIME, outstanding
ortunity to join busy practice in suburb of
roit. Reply to Box 20, Michigan State Medi-
Society, 120 W. Saginaw, East Lansing,
23.

NEED FULL TIME OR PART TIME PHYSICIAN OR P.A. in a busy general practice in semi-rural set-up close to Ann Arbor. Some industrial and insurance physicals. Very interesting and varied. Salary negotiable and commensurate with experience. Please call 313-697-9300 or send resume to Belleville Medical Clinic, 265 Main Street, Belleville, MI 48111.

PHYSICIANS NEEDED IN ROGERS CITY AND POSEN, MICHIGAN. Excellent opportunity for physicians seeking a wide variety of financially rewarding professional experiences. Located near Lake Huron with excellent outdoor and family lifestyle. Attractive income guarantee in solo or group practice settings. If interested, call collect to: Evans Calas, Assistant Administrator, Rogers City Hospital, (517) 734-2151.

CALIFORNIA-DIRECTOR POSITIONS AVAILABLE. Emergency medicine physicians needed for rural Northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit-sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610. 415/832-6400.

PART-TIME PHYSICIAN needed to do routine physicals to assess donor suitability for plasmapheresis. Good position for older physician looking to slow down. Malpractice coverage provided. Contact Thomas Anderson at American Plasma Management, Kalamazoo, MI. Phone 616/381-0086.

Positions with The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Miscellaneous

RECREATION/INVESTMENT Property — Michigan Upper Peninsula. 45+ acres with approximately 600 ft. sand beach frontage on Lake Michigan. Private asphalt drive, 4 year old American Timber Home Chalet — 4 bedroom, 4 bath — full basement with large family/recreation room and wet bar. Front deck, all-electric, Jen-Aire Kitchen. 3-car garage with 2 older out buildings (cottage/boat house). 15 miles south of Escanaba on M-35. Excellent financing plan, $180,000 total. Includes many extras. Call 906-786-8822 if you wish more details.

BATTLE CREEK, Michigan — 4300 square foot Medical-Dental facility. Available in October or November, 1981. Located within two minutes drive of two LARGE HOSPITALS. Country setting with abundant parking. Attractively designed and landscaped. Call Ron Kuhn, 616-968-5200 days, 616-979-1810 evenings.

PORT HURON, Michigan. Modern medical office recently vacated by MD after 15 years. Common reception area, business office, 4 examination rooms, laboratory, lavatory, storage room, and private office — completely carpeted and newly decorated with all utilities including air conditioning and stereo. Close to hospitals, reasonable rent. Call Harold F. Willis, DDS (313) 982-5528.

COMPHEALTH — Locum Tenens — Physicians covering physicians, nationwide, all specialties. We provide cost effective quality care. Call us day or night. T.C. Kolff, MD, President, CompHealth, 175 W. 200 S., Salt Lake City, Utah 84101 (801) 532-1200.

HOWELL, MICHIGAN — Two suites available in attractively designed medical-dental building. Complex conveniently located within walking distance of hospital which serves fastest growing county in the state. Unlimited opportunity for hardworking family practitioner looking to establish large practice. For information, call (517) 546-7630.

SNOWMASS/VAIL "MEP" SKI SEMINAR on Management Enrichment for the Health Professional. Ski Snowmass, Colorado the weeks of December 19, 1981 or March 20, 1982; or Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Trip expenses deductible for doctor and spouse. For information: M.E.P., An Education Corporation, 906 Cooper Avenue, Glenwood Springs, Colorado 81601; or 1-800-525-3402.

HELICOPTER INVESTMENTS — We have available leases, sales, flight instruction, charter and a project consultant to assist you with your helicopter needs. Helicopters, Ltd., P.O. Box 667, 618 Silver Lake Rd., Linden, MI 48451. (313) 735-4121 or (313) 735-9018.

WE HAVE VARIOUS QUANTITIES OF MEDICAL EQUIPMENT available in excellent condition. We buy, sell, trade, move. New equipment also available. Call Doctor Medical Resale, (313) 569-4407, 9 a.m. to 9 p.m.

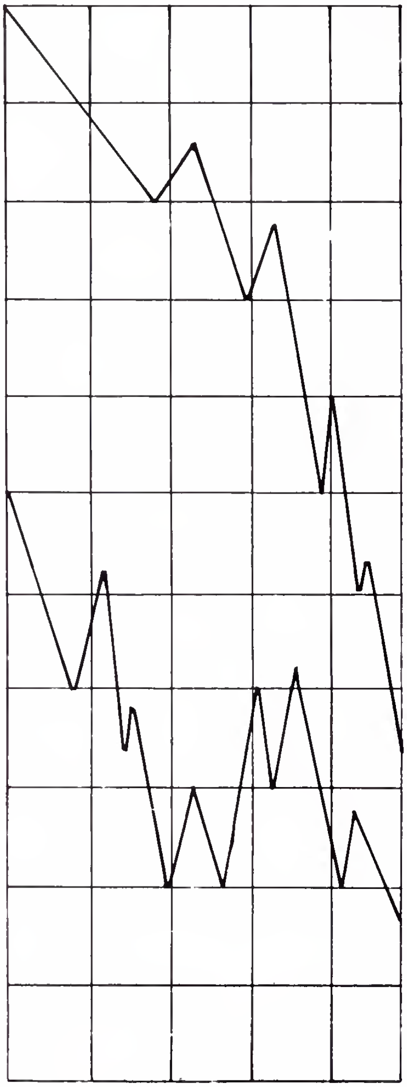
OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

Burt Lakes First Condominium. Directly on beautiful Burt Lake highbanks, spectacular view of the entire length of Burt Lake. Modern, luxury, two & three bedroom units. Near Boyne ski hills. $92,000-$96,500. Furnished unit rentals available for vacation year round. A.K. Smith & Son Realty, Box 578, Indian River, MI 49749. 616/238-9338. Michigan toll free calls 1-800-632-7179.

SANDRA W. COCHRAN, MEDICAL ILLUSTRATOR. Medical illustration available, from detailed realistic renderings to simple diagrams, graphic design and biophotography. For quality illustrations at the lowest cost, call (313) 652-2547, or write 1163 Ironwood Court, Apt. 104, Rochester, Michigan 48063.

Sign up now!

Reagan economist to keynote MSMS Public Affairs Leadership Conference



The Annual MSMS Public Affairs Leadership Conference is being held on October 22, 1981 at the Lansing Hilton Inn, Lansing.

The MSMS House of Delegates challenged MSMS and the medical community to make an aggressive effort to prepare and inform physician leaders. Last year's program featuring Senator Carl Levin and Richard Scammon was a tremendous success.

The 1981 MSMS Public Affairs Leadership Conference will feature Jude Wanniski, supply side economic consultant to Ronald Reagan, and former editorialist for the *Wall Street Journal*, Mr. Wanniski will outline the tremendous national economic policy changes taking place.

Gerald Miller, PhD, director of the Michigan Department of Management and Budget, will candidly discuss the political and fiscal realities of Michigan's budget process.

Check the stimulating program below and register today!

The program

8:30 REGISTRATION

9:30 CALL TO ORDER — Fred E. Patterson, MD, Chairman, MSMS Public Affairs Conference Committee

9:40 OPENING REMARKS — James D. Fryfogle, MD, MSMS President

10:00 "ANTITRUST, HEALTH PROFESSIONS AND MSMS" — William A. Sankbeil, Kerr, Russell and Weber, Detroit

10:30 "THE MICHIGAN BUDGET: FINANCIAL SOLVENCY AND POLITICAL ACCOUNTABILITY" — Gerald H. Miller, PhD, Director, Department of Management and Budget, State of Michigan

11:15 "REAGANOMICS: FROM THE WALL STREET JOURNAL, KEMP-ROTH TO CAPITOL HILL" — Jude Wanniski, President Reagan's Economic Strategist

12:00 LUNCH

1:30 "MSMS: AN AGGRESSIVE ADVOCATE" — Thomas R. Berglund, MD, MSMS Council Chairman

1:45 "AMA BRIEFING: MEDICINES' PRIORITIES" — John R. Coury, MD, AMA Board of Trustees

2:00 "A SUCCESSFUL VOLUNTARY EFFORT — COST CONTAINMENT" — Ruth Gattman, North Central Regional Legislative Chairman, AMA Auxiliary

2:15 "SCOPE AND FUTURE OF THE INDEPENDENT PHYSICIAN" — William R. D. Martin, Dean, School of Management, University of Michigan Dearborn

3:00 "HOW MANY DOCTORS DO WE NEED BY 1995?" — Graduate Medical Education National Advisory Committee (GMENAC) — Robert B. Carbeck, MD, Member of GMENAC Panel, Ann Arbor

3:30 "MEDICINES' OPPORTUNITY UNDER NEW LEADERSHIP" — Ed Annis, MD, Former AMA President

---

Please return to:

1981 Public Affairs Leadership Conference
Michigan State Medical Society
P.O. Box 950
East Lansing, Michigan 48823

Please print or type.

Name ______________________

Address ______________________

____

Name ______________________

Address ______________________

____

For more information:
Please contact Bill Madigan
or Kevin Kelly
at MSMS Headquarters —
517/337-1351.

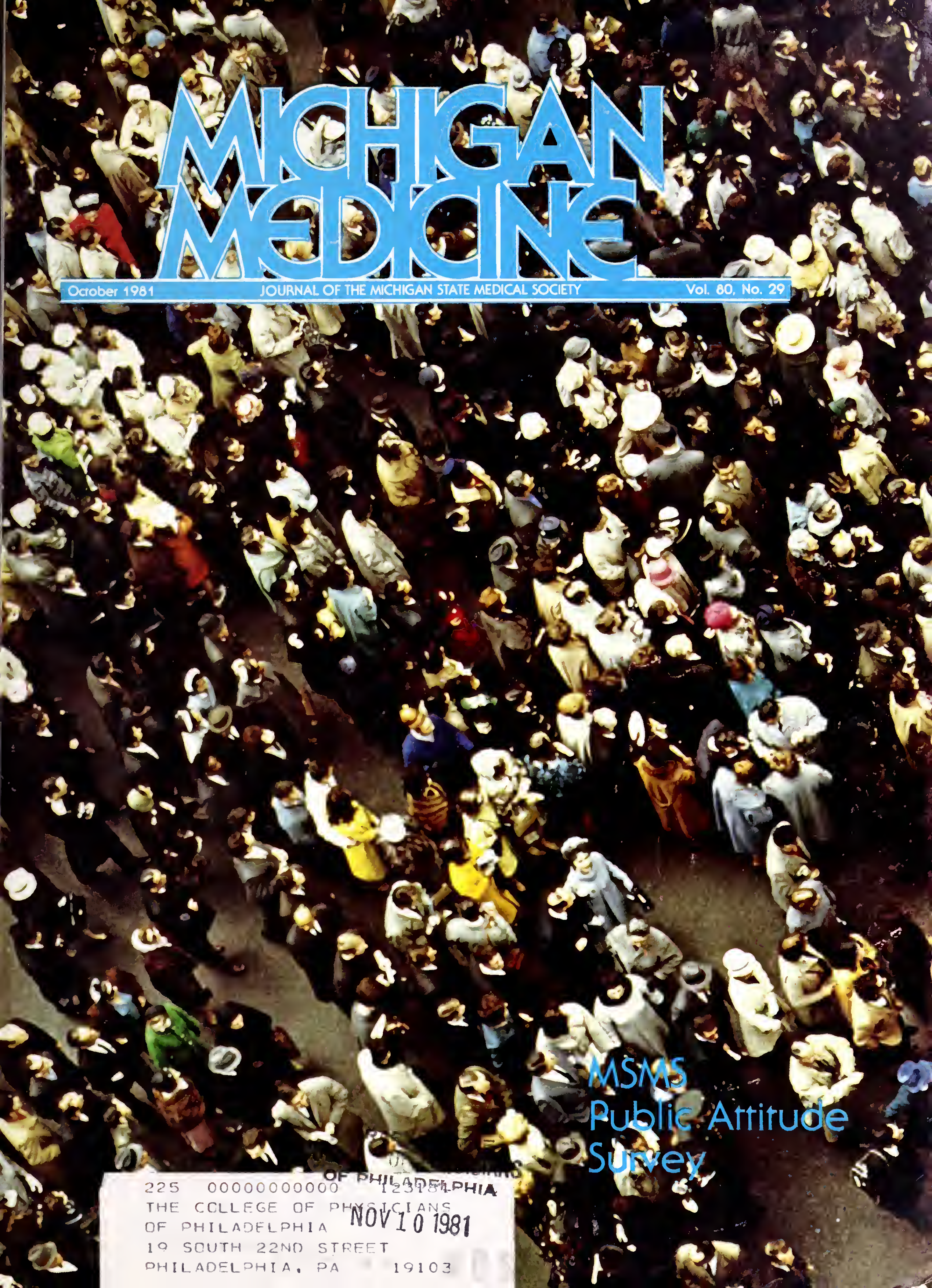
Please check one

☐ Physician ☐ Other ______________________

Registration Fee: $25 includes luncheon

Amount enclosed $ ______________________

Please make check payable
to Michigan State Medical Society



MICHIGAN MEDICINE

October 1981 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 80, No. 29

MSMS
Public Attitude
Survey

225 00000000000 123184
THE COLLEGE OF PHYSICIANS
OF PHILADELPHIA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103
OF PHILADELPHIA
NOV 10 1981

CME
"CME Is Our Bag"

The black bag is a traditional symbol of medicine. MSMS continues its own tradition of quality CME with the 116th Annual Scientific Meeting Nov. 17-18-19 at the Hyatt Regency Dearborn. The MSMS bag may look like yours, but it is different. Instead of holding medications and basic instruments, ours contains more than 50 doses of CME from which you can choose your own course of treatment and earn up to 18 hours of Category I Credit. Come to the MSMS Annual Scientific Meeting and see what our CME bag holds for you!

1981
MSMS ANNUAL
SCIENTIFIC MEETING
November 17-18-19, 1981
Hyatt Regency Dearborn

Attitudes Toward Health Care Issues

Attitudes Toward Health Care Issues of the General Public and Physicians in the State of Michigan

March, 1981

Michigan State Medical Society
Committee on Public Service

Table of Contents

Purpose 1

Methodology 2

- I. Public Survey 2
- II. Physician Survey 4
- III. Statistical Confidence 5
- IV. Ohio Study 5

Findings 5

- I. Quality of Health Care 5
- II. Perception of Professional Training 7
- III. Patient-Physician Relationship 8
- IV. Medical Attitude 12

Summary 17

Purpose

This study was conducted for the Committee on Public Service of the Michigan State Medical Society to help guide its future programs. The study was designed to measure attitudes toward health care and related issues among the Michigan public and among Michigan physicians. A major goal was to compare attitudes held by the public to those held by physicians on the same health care issues.

The health care issues are divided into four general categories; quality of health care, perceptions of professional training, patient-physician relationship, and general medical or health care related attitudes. The quality of health care category includes perceptions of health care in general and the quality of care provided by physicians. In addition, perceptions of the important issues facing health care today were measured. The perceptions of professional training section deals with estimates of the length of training required by various professions. The patient-physician relationship category includes reasons for selecting a physician, health care decision making, and professional fees. The general medical or health care attitude category consists of items dealing with physicians and related topics such as advertising by physicians and health insurance.

Another consideration is the comparability with the 1977 Ohio State Medical Association study. This study, while more concerned with issues of medical malpractice, measured many of the same health care attitudes. A secondary goal was to determine how applicable this study might be to the State of Michigan.

Methodology

The study was conducted by ELRA Group, a Michigan corporation with offices in East Lansing and San Francisco. ELRA Group specializes in survey research and consulting for the telecommunications industry, primarily broadcasters and multiple system cable operators, but does work for a wide variety of clients, including a pharmaceutical company. All fieldwork, data preparation and analysis is completed in the East Lansing office.

The study was conducted in two phases: the public survey and the physician survey. The public survey consisted of a telephone survey of a random sample of Michigan residents conducted by ELRA Group. The physician survey consisted of a mail survey of a random sample of physicians conducted through the Michigan State Medical Society. Each study plan is described separately.

I. Public Survey

The public survey consisted of 609 completed telephone interviews with Michigan residents. A random sample of the entire state was obtained from Survey Sampling, Incorporated. The last digits of the telephone numbers were randomized to insure inclusion of unlisted numbers. The sample includes telephone numbers from both the upper and lower peninsulas. Table I shows how the sample was disposed. Of the original 1,170 numbers, only 942 were usable. ELRA Group completed interviews with persons at 609, or 66% of the 942 usable numbers.

All interviews were conducted between Wednesday, December 17, 1980 and Monday, December 22, 1980. Interviewing on weekdays occurred between 5:30 and 9:00 p.m., Eastern Standard Time, and from 2:00 to 9:00 p.m., Eastern Standard Time on Saturday and Sunday. Each interview lasted approximately 10 minutes.

All interviews were conducted at the ELRA Group central facility. Interviewers were always supervised and periodically monitored to insure quality. Interviewer supervisors all hold graduate degrees in a related field.

The questionnaires were developed in conjunction with Michigan State Medical Society Public Service Committee. The telephone questionnaire was pretested in early December

TABLE I. Disposition of Telephone Public Sample

	Numbers	Percent
Initial Sample	1,170	
Disconnected	139	
Business Numbers	89	
Language Problems	15	
Usable Numbers	924	100
Completed Interviews	609	66
Refused	138	15
No Answer or Busy*	162	17
Other	18	2

*After 5 callbacks

with a small sample from the Lansing area.

The demographic characteristics of the public sample are shown in Table II. It should be noted that in some cases the column totals may be less than 609 because of "don't know" responses or refusals to answer particular questions. Percentages are based only on those respondents answering the question.

TABLE II. Characteristics of the Public Sample

	Number	Percent
SEX:		
Male	297	49
Female	312	51
CHILDREN UNDER 12:		
Yes	212	35
No	396	65
RESIDENCE:		
Rural Area	111	18
Small Town	144	24
Suburban Community	185	30
City	167	27
Education:		
Less than High School	97	16
High School Graduate	194	32
Some College	188	31
College Graduate	127	21
AGE:		
Under 25	70	12
25 to 34	167	27
35 to 49	164	27
50 and over	199	33
OCCUPATION:		
Professional, Managerial & Sales	141	23
Skilled & Technical	103	17
Clerical & Service	108	18
Homemaker	113	19
Self-Employed & Farm	24	4
Student	26	4
Retired	57	9
Unemployed	31	5
INCOME:		
Under $15,000	176	29
$15,000 to $24,999	179	29
$25,000 to $34,999	108	18
$35,000 and over	84	14

II. Physician Survey

The physician survey consisted of 568 completed mail questionnaires with Michigan physicians. A random sample of 998 members of the Michigan State Medical Society was sent questionnaires with cover letters on Michigan State Medical Society stationery. An announcement of the survey was also carried in the Medical Society newsletter. The return rate was nearly 57%.

The questionnaire was developed from the public questionnaire, generally with items rewritten for physicians. Some questions were added which were unique to the physician sample, as well as some deleted. The questionnaires were returned to the Medical Society, and then sent to ELRA Group for analysis. The first questionnaires were mailed January 6, 1981.

The characteristics of the physician sample can be seen in Table III. Again, the numbers may not total to 568 because of non-response to the particular questions. The percentages are also based only on those answering the question. The medical specialties have been aggregated to simplify the analysis. Family practice and general practice are combined under general practice, internal medicine includes dermatology, neurology and cardiology, and surgery includes special surgery, pathology, ophthalmology and urology.

TABLE III. Characteristics of the Physician Sample

	Number	Percent
RESIDENCE:		
Rural Area	31	6
Small Town	125	22
Suburban Community	201	36
City	198	36
AGE:		
Under 35	60	11
35 to 49	248	46
50 and over	235	43
SPECIALTY:		
General Practice	82	15
Internal Medicine	133	25
Surgery	134	25
Pediatrics	43	8
Obstetrics & Gynecology	49	9
Anesthesiology	12	2
Psychiatry	27	5
Radiology	18	3
Emergency Medicine	11	2
Other	34	6

III. Statistical Confidence

Since both the public and physician surveys result from samples, it is necessary to keep in mind sampling error when interpreting the results. Estimates of percentages from the public sample would be within +4.0% or − 4.0% at the 95% level of confidence. The slightly smaller physician sample also would be within +4.1% or −4.1% at the 95% level of confidence. These error estimates are "worst case," and most probably would be less, depending on the proportion being estimated.

IV. Ohio Study

The Ohio Study, as it will be referred to hereafter, is the 1977 survey sponsored by the Ohio State Medical Association. The study consists of 1,500 telephone interviews with Ohio residents, and was conducted and reported by Roger D. Blackwell and W. Wayne Talarzyk, *Consumer Attitudes Toward Health Care and Medical Malpractice* (Columbus, Ohio: Grid, Inc., 1977).

Findings

The findings of both the public and physician surveys are reported together in four sections: quality of health care, perceptions of professional training, patient-physician relationship, and general medical attitudes. Where appropriate, comparisons will be made with the Ohio Study.

I. Quality of Health Care

The quality of health care includes such issues as confidence in being able to get good medical care, the overall quality of medical care, and important issues facing health care today. Quality of health care questions were asked of both the public and physician samples.

Surveyors asked the public sample: "How much confidence do you have in being able to get good medical care for you and your family when you need it?" Physicians were asked, "How much confidence do you believe your patients have . . .?" Table IV shows that about half of both respondents indicate a great deal of confidence. About 9 out of 10, 88% of the public sample and 95% of the physician sample, indicate either a fair amount or a great deal of confidence in beng able to get good medical care. There appears to be a high level of confidence in the health care system, and not any major difference in the perceptions of the public and physicians.

TABLE IV. Confidence in Medical Care

Confidence in Being Able to Get Good Medical Care	Percent Public	Percent Physician
Great Deal	50	55
Fair Amount	38	40
Not Very Much	8	3
None At All	3	1
Don't Know	1	1

The overall quality of health care received by a family is perceived somewhat differently. About one-third (32%) of the public sample rates the overall quality of health care excellent. Physicians answered that only one-fourth (28%) of the public would think so, as shown in Table V. About 9 out of 10 physicians (89%) thought the public would rate the quality excellent or good compared to about 3 out of 4 of the public sample (77%).

TABLE V. Quality of Health Care

Overall Quality of Health Care	Percent Public	Percent Physician
Excellent	32	28
Good	45	61
Fair	18	9
Poor	2	1
Don't Know	3	1

Four health care issues were presented to both the public and physician samples: availability of physicians, cost of health care, better drugs and treatments, and availability of hospital beds. Table VI shows the percent ranking each issue most important among the two samples. Both physicians and the public rank cost of health care most important, although physicians appear somewhat more likely to think the public would rank it first (63% among physicians compared to 45% among the public).

TABLE VI. Most Important Health Care Issues

Importance of Health Care Issues	Percent Ranking First Public	Percent Ranking First Physician
Cost of Health Care	45	63
Availability of Physicians	38	34
Better Drugs and Treatments	11	4
Availability of Hospital Beds	7	4

Examining the complete rankings, as shown in Table VII, provides a picture of the second, third and fourth choices. Physicians thought the public would rank availability of physicians as the second most important issue, which they did.

TABLE VII. Complete Ranking of Importance of Health Care Issues

	Percent Ranking							
	First		Second		Third		Fourth	
Importance	Pub.	Phy.	Pub.	Phy.	Pub.	Phy.	Pub.	Phy.
Cost of Health Care	45	63	21	23	19	8	15	6
Availability of Physicians	38	34	28	43	18	14	16	9
Better Drugs and Treatments	11	4	31	20	38	45	20	31
Availability of Hospital Beds	7	4	19	14	25	30	49	52

The complete rankings of both samples can be directly compared using the law of comparative judgment. The rank order information can be converted to pair comparisons, and then standardized and converted to an equal interval scale similar to a thermometer. The matrices of proportions and normal curve deviates are available from MSMS. Scale values are calculated by adding a constant to both samples. Table VIII shows the comparison between the public and physician samples. Overall, physicians thought the public would consider the cost of health care to be a more important problem, even though both groups consider the cost of health care to be the most important problem. The public considers better drugs and treatments to be more important than physicians thought they would, even though both groups rank it third. Physicians come very close in estimating the public's perception of availability of physicians and hospital beds as a problem.

TABLE VIII. Comparative Judgment Scales of the Importance of Health Care Issues

	Scale Views		
Health Care Issues	Public	Physician	Difference
Cost of Health Care	1.30	1.62	−.32
Availability of Physicians	1.10	1.12	−.02
Better Drugs & Treatments	.63	.39	.24
Availability of Hospital Beds	.18	.07	.11

II. Perceptions of Training

The public sample was asked how many years of college and professional training were necessary for various occupational categories. Table IX shows the median estimates of professional training for all the occupational categories included in the study. Physician training is estimated at 7.8 years, and psychiatrists' at 7.7 years, both substantially below the actual time necessary. Other occupations also are shown.

TABLE IX. Median Estimates of Years of Training

	Estimated Median Years	Actual Time Required
Physician	7.8	11 to 15
Psychiatrist	7.7	11
Lawyer	6.2	7
Psychologist	6.0	8
Podiatrist	5.9	7
Optometrist	5.7	7
Veterinarian	5.6	8
College Teacher	5.5	5 to 8
Chiropractor	5.0	6 to 8
Registered Nurse	4.0	4
Paramedic	2.5	2

Another important number is the percentage of the public sample who correctly estimate the number of years of training required. Table X shows that only 6% of the public estimates the total training time for a physician to be 10 years or more. For psychiatrists, 12% of the public estimates the training time to be 10 years or more. The actual range is shown in bold type. This indicates some underestimation of the training involved to become a physician, and the comparison with other occupations.

TABLE X. Distribution of Years of Training by Occupation

			Percent Years of Training		
	2-3	4-5	6-7	8-9	10+
Physician	1	10	28	41	6
Psychiatrist	2	15	26	34	12
Psychologist	6	28	34	21	4
Veterinarian	11	33	33	17	1
College Teacher	5	43	34	12	3
Chiropractor	16	37	26	14	2
Lawyer	4	26	38	21	3
Podiatrist	8	30	30	21	2
Optometrist	12	32	30	18	2
Registered Nurse	26	56	12	4	1
Paramedic	48	27	8	2	1

III. Patient-Physician Relationship

The overwhelming majority of the public say they currently have a family physician. In the public survey, 85% say they have a physician. This is slightly less than the 90% reported in the Ohio survey, as shown in

Table XI.

About half rate the quality of the health care provided by *their* physician as excellent (49%) as shown in Table XII, which compares very well to the 53% reported in the Ohio study. Nearly 9 out of 10 (87%) rate the quality as either excellent or good. The feeling, however, is not transferred to all physicians. Table XIII shows that only about 1 out of 10 (9%) rate the quality of health care given by physicians in general to be excellent. Only 56% rate the care given by physicians in general to be excellent or good. This compares well with the 59% reported in the Ohio study. Physicians were accurate in estimating the percentage of the public which rates quality of health care excellent, but were high in their estimate of how many would rank quality of health care good. More public respondents rated quality as fair than the physician respondents thought they would. The public, then, seems to have a special perception of their own physicians, but does not look as favorably on quality of health care in general as physicians think they do.

TABLE XI. Currently Have a Physician

Currently Have Physician	Percent Public	 Ohio
Yes	85	90
No	15	10

TABLE XII. Quality of Health Care Given by Own Physician

Quality of Health Care Given by Physician	Percent Public	 Ohio
Excellent	49	53
Good	38	35
Fair	11	10
Poor	1	1
Don't Know	1	1

TABLE XIII. Quality of Health Care Given by Physicians in General

Quality of Health Care Given by Physicians in General	Public	Percent Physicians	Ohio
Excellent	9	12	13
Good	47	71	46
Fair	35	15	32
Poor	4	—	5
Don't Know	5	1	4

About 3 out of 4 (76%) of the public say they found out about their current physician through other people, such as family and friends, as shown in Table XIV. Other sources, such as media, were used by less than 1 out of 5. A complete listing of the verbatim responses is available from MSMS.

TABLE XIV. How Current Physician Was Found

Source	Percent
Other People	76
Media and Other Sources	17
Health Care Facilities	7

Nearly half (47%) of the public sample say the most important reason for selecting their physician is personal recommendations and referrals, as shown in Table XV. Physicians were asked what they thought patients felt was most important, with the results also shown in Table XV. Physicians estimate professional reasons, such as availability, location, specialty, and qualifications as being more important than does the public (39% compared to 32%). Physicians also estimate personal characteristics, such as confidence, communication and concern as being more important (21% compared to 14%). Physicians estimate the importance of referrals and recommendations as less important than does the public (37% compared to 47%). A complete listing of the verbatim responses for this question is also availble from MSMS.

TABLE XV. Most Important Reason for Selecting the Physician

	Percent	
	Public	Physician
Referrals and Recommendations	47	37
Professional Reasons	32	39
Personal Characteristics	14	21
Emergency Need	7	—
Other	—	3

Another important area is the question of professional fees. Table XVI shows the feelings about fees charged by the physician. Over 2 out of 5 (42%) of the public sample say that fees charged by their physician are too high. This compares to less than 1 out of 6 (15%) of the physician sample which thought patients would feel thus, and about 1 out of 4 (27%) of the Ohio study. Just over half (53%) of the public sample say the fees charged are reasonable. The physician sample thought 3 out of 4 (74%) would answer this way. It is also interesting that the Ohio study reports 70% feeling that fees are reasonable, which compares more closely to the estimates provided by physicians.

TABLE XVI. Appropriateness of Professional Fees

Feeling About Fees Charged by Physician	Percent Public	Percent Physician	Percent Ohio
Entirely Too High	11	2	5
Too High	31	13	22
Reasonable	53	74	70
Low	2	5	2
No Opinion	3	6	1

Table XVII shows how often fees are discussed. Nearly 3 out of 5 (58%) of the public sample say that fees are never discussed. Over 2 out of 3 (69%) of physicians report that fees are rarely discussed, and about 1 out of 4 (23%) say fees are frequently discussed. It is interesting that physicians believe that discussion of fees occurs more often than the public says it does. It is also interesting to note that physicians believe that most discussion of fees is initiated (60%) by the patient, as shown in Table XVIII.

TABLE XVII. Frequency of Fee Discussion

How Often Fees Discussed	Percent Public	Percent Physician
Every Visit	7	2
Frequently	9	23
Rarely	26	69
Never	58	7

TABLE XVIII. Who Initiates Fee Discussion?

Who Brings Up Fees?	Percent Physician
Doctor	30
Patient	60
Both	10

The perceptions of decision-making between the physician and patient appear to be perceived as a joint process involving both the patient and physician. Table XIX shows that over 9 out of 10 of both samples believe that the decision should be made jointly (90% of the public and 93% of the physicians). There is some disagreement on who should have the final say, with 53% of the public believing that the patient should have the final say, and 48% of physicians believing that the physician should have the final say.

TABLE XIX. Physician-Patient Relationship

Physician-Patient Relationship	Percent Public	Percent Physician
Physician should make all decisions	5	6
Physician-patient jointly decide, with physician having the final say	37	48
Physician-patient jointly decide, with patient having the final say	53	45
Patient should make all decisions	3	—
No Opinion	2	1

IV. Medical Attitudes

General medical attitudes were measured using a series of statements with which respondents could agree or disagree. To organize the eighteen statements, a factor analysis was performed on the public survey responses, and categories of responses created. The factor analysis is included in the appendix. The general areas include statements involving the fundamental integrity of physicians, the perceived authority of physicians, perceived candor, accessibility, media, and miscellaneous statements. Virtually the same items were administered to both the public and physician surveys, although some items were rewritten for physicians to gauge their perception of the public. Demographic and geographic tabulations of the public survey are included in the appendix.

Table XX shows the percent agreeing with the integrity related statements. Nearly 3 out of 4 (72%) of the public sample believe physicians are dedicated to their work, while 4 out of 5 physicians thought the public would think that way. There is a considerable difference in responses to the statement that most physicians are overpaid. About half (49%) of the public agree, while less than 1 of 10 (8%) physicians agree. About 1 of 5 (21%) of the public agreed that most physicians are more concerned about making money than about the well being of their patients, compared to about 1 out of 20 (6%) physicians. About 1 out of 6 (16%) of the public agreed with the statement that in most cases of patient dissatisfaction, the physician is to blame, while less than 1 out of 10 (8 %) of physicians *disagreed* with the statement that in most malpractice suits, the physician is not really to blame. The Ohio study reports results similar to the public survey.

There are some differences in the public sample by residence. In general, there is less agreement with the statement that physicians are more concerned about money among residents of rural areas and small towns than among residents of suburbs and cities. A similar relationship can be seen among the other items in this group.

Table XXI shows the percentage of agreement with the authority related statements. About 4 out of 5 of both the public sample (81%) and the physician sample (80%) agree with the statement, "I have a great deal of confidence in my physician." This is slightly lower than the level reported in the Ohio study. About 2 out of 3 of both the samples agree with the statement that marijuana is harmful to your health. The greatest difference between the public and physician samples is with the statement that "my physician adequately explains my medical problems to me." About 3 out of 4 (74%) of the public agree with this statement, compared to 1 out of 4 (24%) of physicians who thought the public would answer this way. The physicians were asked, "Physicians adequately explain medical problems to their patients." Again, the public sample agreement is somewhat lower than that reported in the Ohio study. Also, as expected, there are some differences by age group with the statement that marijuana is harmful to your health.

TABLE XX. Agreement with Integrity Related Statements

Integrity Statements	Percent Agree Public	Physician	Ohio
Most physicians are more concerned about making money than the well being of their patients	21	6	20
In most cases of patient dissatisfaction, the physician is to blame	16	8*	15*
Most physicians are overpaid	49	8	40
Most physicians are dedicated to their work	72	80	—

*Disagree with "In most malpractice suits, the physician is *not* really to blame."

TABLE XXI. Agreement with Authority Related Statements

Authority Statements	Percent Agree Public	Physician	Ohio
My physician adequately explains my medical problems to me	74	24	86
I have a great deal of confidence in my physician	81	80	91
Marijuana is harmful to your health	68	67	——

Over 4 out of 5 of both the public sample (88%) and the physician sample (80%) agree with the statement that physicians should be totally frank and open with their patients about their illnesses, as shown in Table XXII. There is some difference, however, in agreement with. "If I had a terminal illness, I would want my physician to tell me." Over 9 out of 10 of the public sample agree, while just over 2 out of 3 (69%) of the physician sample thought the public would agree. The Ohio study reports somewhat less agreement on this last item than does the public survey.

TABLE XXII. Agreement with Candor Related Statements

Candor Statements	Percent Agree Public	Physician	Ohio
Physicians should be totally frank and open with their patients about their illnesses	88	80	—
If I had a terminal illness, I would want my physician to tell me	93	69	83*

*Disagree with, "If I had a terminal illness, I would *not* want my physician to tell me."

Table XXIII shows that about 3 out of 5 of the public sample (61%) agree with the statement that physicians do not spend enough time helping patients understand their illnesses and the treatments they need and physicians correctly estimated this figure. It is interesting that about 2 out of 5 in the public survey agree that patients can get appointments with their physician within 24 hours, while just over 1 out of 5 (24%) of physicians thought the public would answer that way. Also, over 4 out of 5 (82%) of the public survey agree that there are times when there are unsatisfactory results despite the efforts of a physician.

TABLE XXIII. Agreement with Accessibility Related Statements

Accessibility Statements	Percent Agree Public	Physician
Patients can get appointments with their physician within 24 hours	41	24
Physicians do not spend enough time helping patients understand their illnesses and the treatments they need	61	60
There are times when there are unsatisfactory results despite the efforts of a physician	82	—

Table XXIV shows that the public believes they have more problems finding physicians than physicians think they do. Nearly 3 out of 5 (68%) of the public agree with the statement, "patients have a great deal or some problems in finding physicians," compared to about 1 out of 3 (34%) of the physician sample who thought the public would answer that way.

TABLE XXIV. Agreement with the Availability Statement

Availability Statements	Percent Agree Public	Physician
Patients have a great deal or some problems in finding physicians	58	34

About 4 out of 5 (82%) of the public sample agree with the statement, "I wish there were brochures which explained things to me when a doctor treats me." This compares to just over half (54%) of the physician sample which thought that would be the answer, as shown in Table XXV. The comparison reverses for the statement, "I often watch TV programs that discuss health problems." Here about half (56%) of the public sample agree, and 3 out of 4 (74%) of the physician sample thought the public would answer that way. Again, the Ohio study reports results similar to the public sample.

TABLE XXV. Agreement with Media Related Statements

Media Statements	Percent Agree Public	 Physician	 Ohio
I wish there were brochures which explained things to me when a doctor treats me	82	54	77
I often watch TV programs that discuss health problems	56	74	60

TABLE XXVI. Agreement with Miscellaneous Statements

Miscellaneous Statements	Percent Agree Public	 Physician
Physical exercise is very important for good health	96	87
My health insurance is adequate*	78	44
Physicians should advertise	40	5

*Most patients health insurance is adequate.

Table XXVI shows the agreement with three miscellaneous statements. Both the public and physicians agree that physical exercise is very important for good health with about 9 out of 10 of both samples in agreement. About 3 out of 4 (78%) of the public sample agree with the statement that my health insurance is adequate, compared to less than half (44%) of the physicians who thought their patients' insurance is adequate.

It is interesting that opinion is almost equally divided among the public sample on the question of physician advertising. About 2 out of 5 (40%) of the public sample agree with the statement that physicians should advertise compared to 1 out of 20 (5%) of physicians, as shown in Table XXVI. Slightly more of the public, 42%, disagree that physicians should advertise.

Another method of examining differences in physician and public attitudes is to systematically review how variables "separate" a group of individuals. Discriminant analysis is a statistical method that permits this type of examination. Consider the analysis described in Table XXVII. In this case, a group of individuals are interviewed about certain issues. Of course, we could be interested *overall* in people's perceptions and responses to these issues as we have described elsewhere. Examining responses overall we could classify individuals by some characteristic, in this discussion, by whether or not they are a physician or not, and then see what differences there are by comparing the responses of one group with the other. However, such simple between groups comparisons often obscure the presence or absence of subtle differences, primarily because members of one group may be responding in the same way as some or all of the members of another group on a particular issue. If the groups were really dissimilar (or identical) on a particular general medical attitude then group members should consistently respond according to their group identification.

People, of course, are not that alike in their attitudes regardless of their group identification. For some attitudes, even though there may be apparent differences between physicians and others when each group is examined as a whole, some members of the physician group (or the general public group) may feel like members in the comparison public group, and they in turn different from the rest of the physicians and general public. Thus, some attitudes can be a poor discriminator of group differences, and hence of considerably less importance in presenting a composite picture of the position of one group or another.

Notice that in Table XXVII, of the 18 attitudes examined about the role of physicians and their patients, only 8 are of any importance in discriminating between physicians and the general public; the rest cannot be said to either be strongly (or weakly) related to membership in a group. That is, the rest are not uniquely associated with either group.

Notice from Table XXVII that perception and attribution of blame in malpractice suits is the singular attitude that is most uniformly and divergently expressed by physicians and the general public. The second most discriminating variable between the physicians and the general public is one dealing with communication: perceptions of the adequacy of explanations about medical problems afforded patients. Other attitudes that strongly identify and distinguish physicians and the general public include attitudes about physician pay, their right to advertise their services, and as less strong discriminators, attitudes about the adequacy of patients' health insurance, exposure to televised health programs, obtaining physicians brochures, and locating a physician.

In examining Table XXVII the reader should also look at the columns of means for each group, because they indicate not only relative average score differences between the groups, but the *direction* of the differences. Furthermore, the discriminant coefficients should be interpreted as weights, the larger the score (e.g., .74 vs .19) the more the attitude is uniformly believed by each group, even though there are apparent and significant differences in the way each group feels about the issue. The negative sign in front of each coefficient can be ignored in this discussion.

TABLE XXVII. Discriminant Analysis: Physician vs. Public Differences in General Medical Attitudes

	Coefficients	Average Physician	Public
In most cases of patient dissatisfaction, the physician is to blame	.74	1.58	2.78
My physician adequately explains my medical problems to me	.45	1.43	2.18
Most physicians are overpaid	−.33	1.83	2.60
Physicians should advertise	−.25	2.04	2.66
My health insurance is adequate	−.24	1.94	1.38
I often watch TV programs that discuss health problems	.19	1.78	1.34
I wish there were brochures with explained things to me when a doctor treats me	−.14	1.60	1.29
Patients have a great deal or some problems in finding physicians	−.16	2.10	1.72

Note: For these items, Agree = 1, Neutral = 2, and Disagree = 3. Thus, the higher the mean the average, the more disagreement was expressed with the item described on the left. (Wilks Lambda: .32: Chi Square = P .001).

Summary

The overwhelming majority of the general public in the State of Michigan has confidence in being able to get good medical care and most physicians estimated they would feel that way. While most of the public rates the quality of health care as good or excellent, physicians thought more of the public would rate the quality as excellent in these categories than the public actually did. The public rated the cost of health care, followed by the availability of physicians, as the two most important health care related issues, as physicians thought they would.

The public substantially underestimates the length of training involved to become either a physician or psychiatrist. Less than 1 out of 10 of the public is able to correctly estimate the length of training. In other health related career areas, such as registered nurse and paramedic, the estimates are reasonably close to the actual time required.

In terms of the patient-physician relationship, the majority of the public say they have a family physician. It is most interesting that the public tends to rate the quality of health care provided by their physician considerably higher than the quality of health care provided by physicians in general. Most of the public say they found their physicians through other people, and about half of the public say that referrals and recommendations are the most important reason for the selection.

It is interesting that about half of the public believes that fees charged by a physician are reasonable, whereas physicians thought three-fourths of them would. There is also some disagreement between the public and physicians on how often fees are discussed. The majority of the public say never, while the majority of physicians say rarely. It is also interesting that physicians say that most of the time discussion of fees is initiated by the patient.

Both the public and physicians agree that in terms of the patient-physician relationship, the patient and physician should make decisions jointly. There is minor disagreement on who should have the final say, the patient or the physician.

In terms of general medical attitudes, the majority of the public believes that most physicians are dedicated to their work and more concerned about the well-being of their patients than about making money. There is some disagreement regarding whether or not physicians are overpaid. With perhaps the exception of the issue of physicians being overpaid, the public holds the integrity of physicians in high regard.

The majority of the public say they have a great deal of confidence in their physician, and that their physician adequately explains their medical problems. Physicians, however, sharply disagree that patients feel this way. Both the public and physicians agree that physicians should be totally frank and open with their patients about their illnesses, although fewer physicians believe patients would say those with terminal illnesses should be told.

Over half of the public says that physicians do not spend enough time helping patients understand their illnesses and the treatments they need and physicians correctly estimated that percentage. The public believes they can get appointments with their physician within 24 hours in somewhat greater proportion than physicians, although still less than half of the public believe they can get appointments. The public is about twice as likely to agree as are physicians that patients have a great deal or some problems in finding physicians.

There are some differences between the public and physicians regarding media related statements. The majority of the public agree that brochures would be helpful, while only about half the physicians agree. Also, physicians believe their patients watch more TV programs than the patients say they do.

The public expresses considerably more confidence in the adequacy of their health insurance. About half as many physicians agree that their patients health insurance is adequate.

Very few physicians agree that physicians should advertise. Only about 1 in 20 Michigan physicians agree. This compares to an almost even split among the public.

Acknowledgments

Michigan State Medical Society Committee on Public Service

Robert D. Burton, M.D., Chairman
Henry J. Barsch, M.D.
Archie W. Bedell, M.D.
Marshall J. Blondy, M.D.
Mark G. Campbell, M.D.
Robert L. Cross, M.D.
Clyde R. Flory, M.D.
Richard H. Gascoigne, M.D.
David W. Hills, M.D.
William K. Howard, M.D.
H. Ross Hume, Jr., M.D.
John L. Isbister, M.D.
Sidney D. Kobernick, M.D.
John H. Libcke, M.D.
Frederick J. Margolis, M.D.
Thomas C. Payne, M.D.
Richard R. Royer, M.D.
Norman Anderson, Advisor
Donna Chase, Advisor
Michael Killian, Advisor
S.A. Yannitelli, Advisor

Michigan State Medical Society Staff

William E. Madigan, Assistant to Director
Merwyn G. Scholten, Chief of Communications

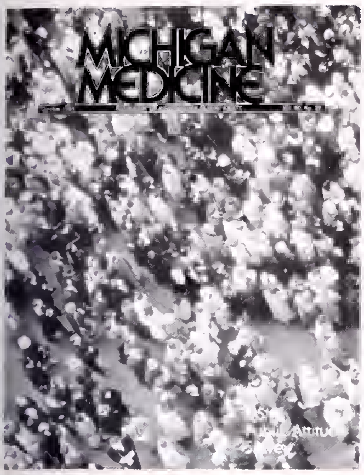
Michigan State Medical Society Consultants

A. Mark Battaglia, President, Capital Advertising
Elmer White, Communications Consultant

ELRA Group, Incorporated

Martin P. Block, Ph.D., Associate

Michigan State Medical Society
120 West Saginaw   East Lansing, MI 48823



The 1981 MSMS survey of public and physician attitudes toward medical care in Michigan is the subject of this month's cover and special report. **(Photo by Ewing Galloway of New York City)**

MICHIGAN MEDICINE

October 1981, Volume 80, No. 29

Special report

516 MSMS just surveyed what the public thinks about medicine in Michigan, and what physicians think the public thinks. The results, which include some surprises but are mostly reassuring for physicians, are reported in the pages of this issue. The entire survey results are printed in a new MSMS booklet which is bound in with this issue, between pages 556 and 557. MSMS is using this new knowledge of public and physician attitudes as a base for an intensified public service effort; Robert D. Burton, MD; Mert Scholten

Features

522 Registration form and program, MSMS Public Affairs Leadership Conference

524 Registration form and program, MSMS conference on "Stress and the Contemporary Woman"

526 Final rundown of details of the 1981 MSMS Annual Scientific Meeting

529 AMA health education director sees public receptive, but few dollars available; Martha Boyce

532 Text of MDs', DOs' Medicaid utilization proposal

540 How the new tax laws affect estate and gift tax changes; Thomas L. Geer, Esq.

542 Computers: Service bureau or 'turnkey' system? Jeffrey Rich

550 Malpractice: In 1981 and . . .; Louis J. Regan, MD

Departments

512 In my opinion; Busharat Ahmad, MD

513 Letters

552 MSMS/A; Dorothy Csonka

554 Medical newsfronts

556 New members

558 News

560 Views; A. B. White, MD; Willah Weddon; Harry A. Schwartz

566 Meetings

568 Category I courses

570 Classified ads

571 Deaths

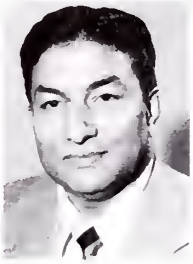
571 Ad Index

572 President's page; James D. Fryfogle, MD

IN MY OPINION

What's your reaction to satellite clinics' impact?

By Busharat Ahmad, MD
Marquette



This is my first opportunity to write for *Michigan Medicine* as chairman of the Publications Committee.

Thus, I want to begin by telling my fellow MSMS members that I feel we can make *Michigan Medicine* more representative of our ideas, thoughts and opinions.

The magazine is an excellent vehicle for communication between its members, the leadership and the MSMS executive offices. This publication has come a long way; and with its emphasis on the socio-economic side of medicine in Michigan, I feel it has done an excellent job. The credit should go to the membership and its readers, and especially to the participants and the authors.

I would really like to see more members, especially in the outstate areas, let us know their feelings, thoughts, constructive criticism and especially suggestions about the issues concerning medicine in Michigan and around the country.

We hear regularly from the leadership of the society through articles and comments, and that is good; but I also would like to encourage the members, especially of the specialty societies and the local medical societies, and our FMG colleagues, to write for the magazine and let us know what they are thinking.

I would like to see these MSMS members contribute an article or letter to the editor or just convey their opinions to the Publications Committee. That would make *Michigan Medicine* more representative. I also would like to know the value of *Medigram*. Does it get the latest news to you at the earliest possible time? Would you like to see it expanded with regard to its content and frequency?

Our goal is communication, and we would like to serve the membership better in every way possible.

Let me suggest an issue that may trigger some letters and comments: the encroachment on the private practice of medicine by health care "providers" such as HMOs and hospital satellite clinics.

We, as independent private physicians, are passing through difficult times. The prepaid medical care plans and the clinics not only look good to the third party payers, the unions and the corporations, but also, sadly, to our own colleagues, who also are falling prey to this system of socialized medicine.

I think prepaid medical care might look easy and lucrative in the beginning. But in the long run, I believe it ends up in poor or less-than-optimum medical care for our patients. I hope we can all keep the best interests of our patients in mind when deciding our future and the future of medicine.

Doctor Ahmad is an ophthalmologist and is chairman of the MSMS Committee on Publications.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
John R. Ylvisaker, MD, Pontiac

Editor
Judith Marr

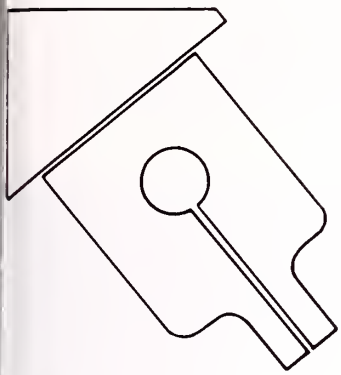
Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $20.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. ©1981 Michigan State Medical Society.

LETTERS



ACLU handbook

I always try to read issues of *Medigram* as a capsule of new events. *Medigram* is both timely and informative.

In the August 6, 1981 *Medigram*, I read about a new handbook on the rights of doctors, nurses and allied health professionals. I am interested to obtain a copy of this Handbook but the address of the American Civil Liberties Union and how to obtain the Handbook were not mentioned.

I believe for information such as this it would be helpful to indicate the address and if possible how it can be obtained.

B. Faiz, MD
Monroe

Editor's note: Several requests have been received by Michigan Medicine for copies of the ACLU handbook. For those physicians who would like to write for copies, the address is:

Literature Department
American Civil Liberties Union
1110 Woodward Tower
10 Witherell
Detroit, 48226
Cost: $3.95

Billing Blues

"Blue Cross Blue Shield — don't get sick without it."

I am the office manager of an orthopedic surgeon's office. I hold current registrations in two medical technical fields, and consider myself of average intelligence.

Of all the insurance companies I deal with, the most complicated is the Blues. Billing them is a real problem. If they make an error in processing a claim it is very difficult to plod through the red tape involved to get it corrected.

For example, one of our patients had a major surgery which involved an assisting surgeon. The assisting surgeon billed for his services as an assisting surgeon and the "Blues" graciously paid his charge as the primary surgeon. When we billed for our services as the primary surgeon the Blues sent our patient a note stating that the service had been previously paid. Upon looking at a copy of both of the forms sent to the Blues, both of them had been submitted correctly as primary and assisting surgeons.

When I called the Blues to notify them of the error, I was told that the assisting surgeon would have to send in a form stating that they had been paid in error. This was not acceptable to me. They could care less about our billing; they had already been paid. I was then told that our patient (their subscriber) would have to request a correction in the error.

As difficult as it is for someone who deals with insurance to understand this problem, it is almost impossible for someone without experience to understand it. When detailing some of these problems to the Blues, you must deal in code numbers for services and diagnoses.

Another problem with billing the Blues is the fact that they consider the care of fractures and the application of casts surgery. The poor soul that breaks both arms or legs is in trouble. (This is not an uncommon occurrence.)

When submitting a claim for care of a fracture of both arms, for example, the Blues consider this two "surgeries" in one day and do not pay on both of them. In the same line of logic, they also consider the application of the casts for this injury "surgery," so they are right back in the same boat with two "surgeries" in one day.

I have had a number of other problems which would require a documentary news program to detail.

One of the biggest problems with the Blues involves trying to reach a human being that isn't programmed to automatically say, "Sorry, this isn't my department."

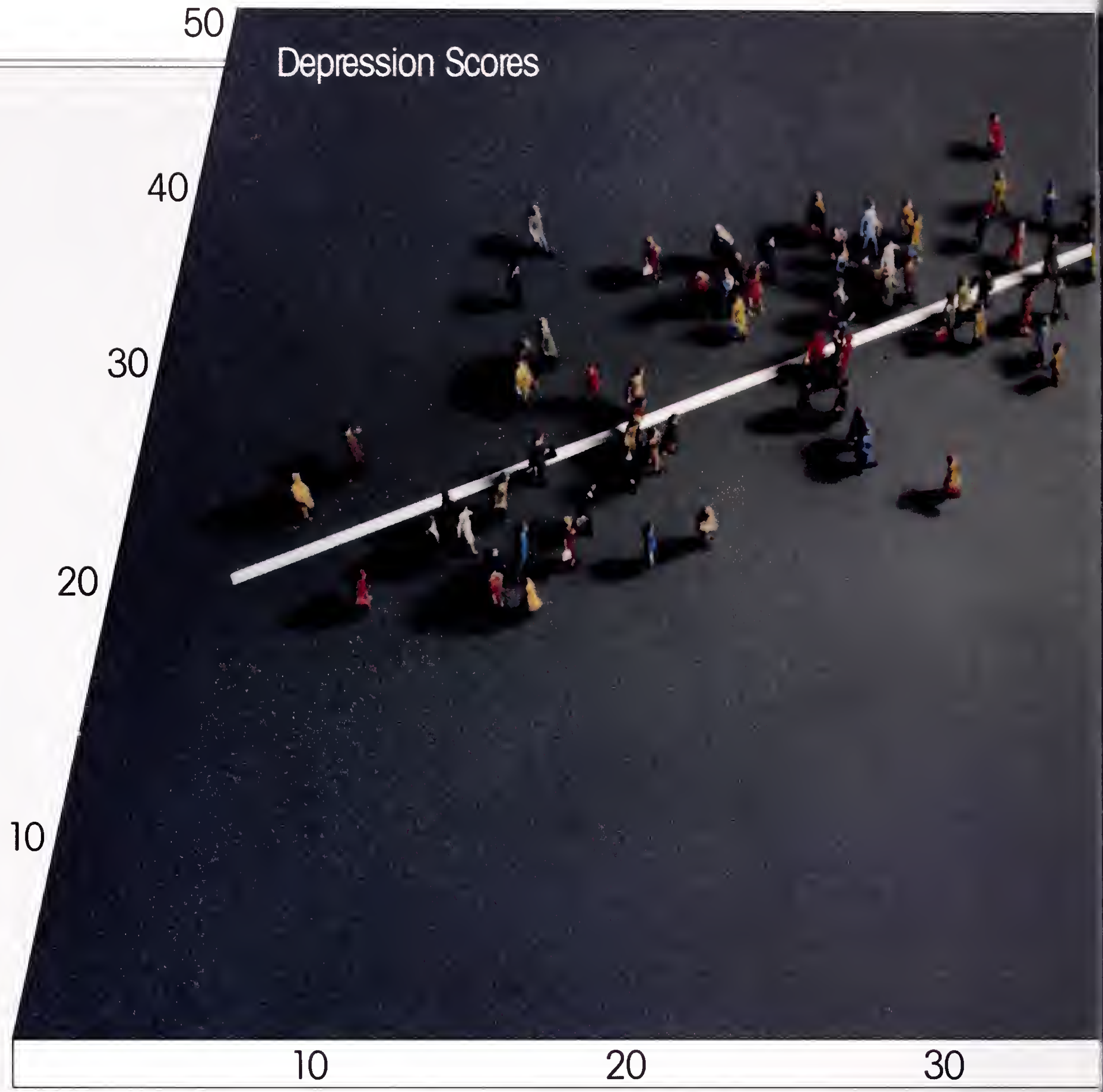
The Blues have gotten so large and out of control that they don't care about their small mistakes. When I tell their professional consultant about their mistakes, his excuse is that they must operate the way they do to stay within State regulations.

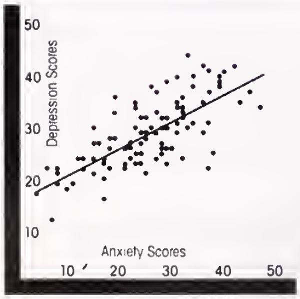
Since they are a non-profit organization it seems that they could be a little more receptive to the problems of their subscribers. After all it is (subscribers') premiums that pay most of their overhead.

Thank you for allowing me to express my opinion.

Sue Sifton, RT, RDMS
Hastings

FOR THE 7 OF 10 NONPSYCHOTI





Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3] Adapted from Cloghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]

Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Claghorn J: The anxiety-depression syndrome. *Psychosomatics 11*:438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61*:217-225, 1979.

In moderate depression and anxiety

Limbitrol® CIV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses Myocardial infarction and stroke reported with use of this class of drugs) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving)

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients Periodic liver function tests and blood counts are recommended during prolonged treatment Amitriptyline component may block action of guanethidine or similar antihypertensives Concomitant use with other psychotropic drugs has not been evaluated sedative effects may be additive Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment See Warnings for precautions about pregnancy Limbitrol should not be taken during the nursing period Not recommended in children under 12

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects

Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs

Cardiovascular Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido

Neurologic Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns

Anticholinergic Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels

Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive I.V administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment

Dosage: Individualize according to symptom severity and patient response Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime Single *h s* dose may suffice for some patients Lower dosages are recommended for the elderly Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12 5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50

ROCHE®

ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

SPECIAL REPORT

MSMS public servi

By Robert D. Burton, MD
Grand Rapids

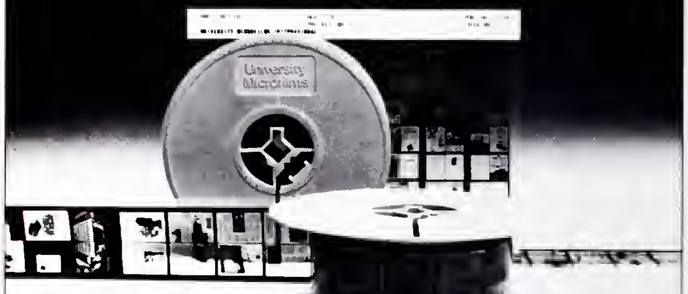
If asked to summarize in a single philosophical statement the basic goal of the MSMS Committee on Public Service, I would say that it is to educate our "publics" on medical matters affecting their lives and health. Part of this goal would be helping the public to obtain the best medical care possible and improving public access to competent medical care.

Another important part of the picture would be to support and encourage the private practice of medicine while maintaining our position of support for the pluralistic approach to health care delivery

---

Doctor Burton is chairman of the MSMS Committee on Public Service.

This publication is available in microform.



University Microfilms International

Please send additional information
Name
Institution
Street
City
State   Zip

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London W1N 7RA
England

mmittee emphasizes education

The public

We need to educate the general public about what a physician is, about what our work entails, and about the amount of education required to practice medicine.

We need to tell the public why the doctor is the person to turn to when illness or accident strikes.

Concurrent to this activity, we must help the public to better understand the financial realities of medical practice in an inflationary economy. There seems to be a broad misconception that any money paid to a physician is simply clear profit just as though a doctor has no operational overhead to his practice. We are developing approaches now to deal with this problem.

Our members

And as for our membership public, I believe we have an obligation to help develop effective spokespersons for our profession, while helping our members to develop greater patient-relations techniques for employment in their individual offices.

Public relations, for all its definitions, remains an elusive commodity. It seems that almost everyone has his or her own definition of what "good PR" means. The simplest definition I've yet encountered is the one that says 'Public relations is doing a good job and telling others about it."

I suspect we have MSMS members who honestly believe that if we just hire the right major New York PR firm and spend enough money we could solve all of our problems and have "good PR." Would that really be the solution? I think not.

As physicians, most of us have very solid relationships with the

continued on page 518

Conversations with over 600 form basis for MSMS survey

There is a lot of good news and relatively little bad news for physicians in a recently completed physician attitude survey undertaken for the MSMS Committee on Public Service by an East Lansing research organization.

The accompanying article highlights some of these findings and points to areas which offer opportunity for physicians to develop better rapport with their patients and the public.

Responses from the "public" represent conversations with 609 scientifically-selected individuals representing a cross section of Michigan society. A separate survey of physician attitudes brought 568 complete returns from 998 questionnaires sent to a random sample of MSMS members.

"We now have a basis on which to build some programs aimed at correcting misinformation and at addressing some attitudes," notes Robert D. Burton, MD, Chairman of the MSMS Public Service Committee.

"The survey results give us a cornerstone for the MSMS PR effort called for by last year's House of Delegates and reaffirmed by the 1981 House," he added. "We won't be whistling in the dark or tilting at windmills as we implement our program for the rest of 1981 and into 1982."

Doctor Burton

majority of our patients. But collectively we are suspect in the eyes of the public. We are often misunderstood, accused of avarice and simultaneously admired and hated.

Faced with this mixed set of problems and expectations, what then can be the most logical approach for an MSMS public relations program?

I believe it is a given fact that MSMS can do little as an organization to change public attitudes about medicine. Nor can it do much to change individual patients' attitudes about their doctor. Only physicians, through development of stronger human relations qualities can truly affect any change in attitude.

MSMS is not copping out by suggesting that good PR is a matter of individual doctor-patient relationship. On the contrary, your public service committee recognizes that MSMS must address those activities which the individual doctor cannot do for him or herself. We believe the efforts we've undertaken in the past months are achieving greater recognition for MSMS and accrue to the benefit of all physicians.

MSMS projects

Let me summarize quickly some of the activities we've developed which are not mentioned in the accompanying report summarizing the results of our survey of the public and physicians.

During the current year MSMS has produced a series of radio and television public service spots, launched a medical news feature service and is about to release a special half-hour program for cable television outlets entitled "Did Anyone Call the Doctor?"

Additionally, we are in the process of developing a brochure, "When Illness or Injury Strikes," which will be distributed on a mass basis through our members' offices and through the Michigan Department of Transportation.

And to fulfill a mandate from the House of Delegates, we are soon going to be sending to racquetball and handball facilities across the state a poster reminding participants to wear protective eyewear during play.

The committee has recommended a comprehensive program for 1982 to the MSMS Council. Particular of the program will be shared with our membership on a periodic basis over the next several months.

MSMS is on the move. Our public relations is a strong, comprehensive approach which seeks to address problem areas, identify objectives and goals, while retaining flexibility to meet unforeseen challenges.

Cost, quality of medical

By Mert Scholten
East Lansing

- The Michigan public has a good deal of confidence that it receives high quality medical care from its doctors.
- More than half of respondents in a study of public attitudes toward doctors believe that fees charged by physicians are reasonable.

The conclusions above are among highlights of a two-part comprehensive survey undertaken earlier this year by the Michigan State Medical Society Committee on Public Service.

A total of 609 telephone calls were completed with a scientifically selected sample of Michigan citizens in an effort to learn how the general public views medical matters. A different survey, conducted by mail with MSMS members, brought 568 returns from a random sample of 998 physicians.

When asked the question "How much confidence do you have in being able to get good medical care for yourself and your family when you need it?" 88 percent of the public 609 respondents indicated that had either a "great deal" (50%) or a "fair amount" (38%).

On the physician survey the question was asked of doctors, "How much confidence do you believe your patients have in being able to get good quality medical care?" Fifty-five percent of the physicians responded with "a great deal," while 40 percent believed patients would respond saying "a fair amount."

East Lansing Research Associates, which conducted the public survey and tabulated the responses of both surveys, concludes in its report that "there appears to be a high level of confidence in the health care system, and not any major difference in the perceptions of the public and physicians."

As for quality of the health care delivered, 32 percent of the public ranked it "excellent," 45 percent ranked it "good," 18 percent said it is "fair." Thus 77 percent ranked the quality as either good or excellent. Physicians surveyed on this same question thought the public would respond 28 and 61 percent, respectively, to the "excellent" and "good" categories.

Cost

As could be safely predicted, the cost of health care was selected most often from a list of four health care issues currently facing Michigan citizens and physicians. Forty-five percent of the respondents placed cost of health care as the most important issue in current health care, while the physicians ranked it first. Sixty-three percent placed it at the top of the list.

Availability of service

Contrary to recent reports of a Michigan physician surplus, 38 percent of the public cited unavailability

Mr. Scholten is MSMS chief of communications.

care ranked in MSMS survey

of physicians as the primary problem among the health care issues. Next came better drugs and treatments, and unavailability of hospital beds.

The public respondents' perception that unavailability of physicians is their biggest problem is particularly interesting in light of the fact that 85 percent of those surveyed indicated they currently have an established relationship with a physician they can call "my doctor."

MSMS public service projects today

Here are more MSMS public service activities . . .

1. Five public service TV spots and four radio spots which have received $200,000 in air time and still are being used.
2. Medical news features on medical topics and specialties for all Michigan papers every two weeks. Some 40-50 are using service.
3. Travel brochure for public, "If Illness Strikes While You're Away," for massive distribution this fall through doctors' offices and Michigan Transportation Department.
4. A half hour, made-for-cable-television program "Did Anyone Call the Doctor?" to be released in October
5. A poster for racketball/handball courts throughout the state reminding participants to wear protective eyewear.
6. A campaign to educate the public about Medicaid, noting the extent to which the program is subsidized by physicians.
7. An effort to encourage physicians to have patient information pamphlets available explaining practice, office hours and other needed patient information.
8. A program to reach residents, students, and non-members to inform them of MSMS activities and programs, and services.

Appreciation of training

One of the more interesting discoveries in the study from the public service committee's standpoint is the public perception of the time required to become a physician. While the public respondents accorded doctors the greatest number of years required to become professionals, estimates were substantially below the actual training time required.

The question on the survey was, "How many years of college and professional training are necessary to become a . . .?" Results of the tabulation showing median estimates of years of training were:

Physician	7.8 years
Psychiatrist	7.7 years
Lawyer	6.2 years
Psychologist	6.0 years
Podiatrist	5.9 years
Optometrist	5.7 years
Veterinarian	5.6 years
College Teacher	5.5 years
Chiropractor	5.0 years
Registered Nurse	4.0 years
Paramedic	2.5 years

There are obviously a substantial number of people who are simply not aware of the amount of training required to become a physician. This indicated to the Public Service Committee a need for educational efforts directed at the public to make people aware of just what is required in a comprehensive medical education.

Only six percent of the public surveyed correctly believed that it takes 10 or more years to become a physician (based on four years of college, four years of medical school, and the usual three or more years of residency training.) On the other hand, 12 percent of the respondents believed it took 10 or more years to become a psychiatrist. A total of 39 percent believed a physician's training was completed within two to seven years after high school graduation.

When asked to rate the quality of health care given by their own doctor with that provided by all doctors, 87 percent labeled it as good or excellent (38 percent and 49 percent, respectively) but only nine percent gave an excellent rating to the profession as a whole. Another 47 percent classed the quality of health care in general as "good."

Selecting a doctor

It appears good reputation is still a doctor's best ally, as 76 percent of the public respondents said they found their current physician through references from other people, including family, friends and satisfied patients. Only 17 percent indicated they used media sources, including yellow pages, physician directories and formal referral services.

Nearly half (47 percent) of the public sample said the most important reason for selecting their physician was personal recommendation and referral. This figure is 10 percent higher than physicians believe, according to the MSMS survey. Only 37 percent of physicians responding thought patients chose doctors on referral or recommendation.

Some 32 percent of the public chose their current doctors for professional reasons (i.e. specialty, outstanding credentials, training background). This figure was slightly lower than that estimated on the physician survey where 39 percent of the doctors thought they were chosen for professional reasons.

Surprisingly, 21 percent of the physicians thought they were chosen for their personal characteristics, yet only 14 percent of the public indicated they chose their doctor for that reason.

Advertising

The appropriateness of physician advertising was brought out in the survey. Respondents were asked to agree or disagree with the statement, "Doctors should advertise." An even split occured with 40 percent agreeing and 40 percent disagreeing. On the other hand, only five percent of the physicians surveyed agreed with the statement.

Given that a vast majority of persons surveyed already have physicians, and that relatively few people select their doctors using directories or media, it is perhaps no surprise that there would be a division of opinion on the issue of physician advertising.

It would appear that those favoring physician advertising do so largely as a matter of obtaining information about health care and its practitioners. This is borne out somewhat in the response to a related item on the survey.

Sources of information

Eighty two percent of the respondents agreed with the statement "I wish there were brochures which explained things to me when a doctor treats me." On the other hand, physicians guessed that only 54 percent of the public would respond this way to the statement.

By the same token, only 56 percent of the public agreed that "I often watch TV programs that discuss health problems," while physicians thought that 74 percent would agree with the statement.

"Obviously, the public is more interested in obtaining as much information as possible about their illnesses and problems as they can," notes Robert D. Burton, MD, chairman of the MSMS Public Service Committee which authorized the survey. "I feel the survey has given us a sense of direction in pointing out some areas of concern. The committee is now trying to develop programs which will address the needs and concerns highlighted by the survey."

Costs of service

While 53 percent of those surveyed agreed that physician fees are "reasonable," a total of 42 percent thought they were "too high or entirely too high." On the other hand, 70 percent of the doctors thought the public would see the fees as "reasonable" while 27 percent of the doctors guessed the public would rate the fees as "too high or entirely too high."

Of interest in relation to the fees questions were the responses to four so-called "integrity" statements offered in the questionnaire.

Twenty-one percent of the public agreed with the statement "Most physicians are more concerned about making money than about the well-being of their patients." Nearly half (49 percent) of the public believes that "Most physicians are overpaid," yet 72 percent believe "Most physicians are dedicated to their work." Encouragingly, only 16 percent of the public agreed with the statement "In most cases of patient dissatisfaction, the physician is to blame."

Communication

The survey turned up some apparent contradictions as well. "My physician adequately explains my medical problems to me" was agreed to by 74 percent of the public respondees, yet on another survey item 61 percent agreed with the statement "Physicians do not spend enough time helping patients understand their illnesses and the treatments they need."

"Perhaps this contradiction can be explained as a perceptual difference between the patient's relationship with his personal physician as distinct from a perception of the profession as a whole," notes Doctor Burton. "Given the expressed desire for more information about their medical problems, as noted on another survey item, there seems to be little question, however, about the need for us as responsible physicians to continue to open the communications lines with our patients."

Life style

Areas of greatest agreement between the public and physicians in the survey occurred in response to two items. "Physical exercise is very important for good health" was agreed to by 96 percent of the public with 87 percent of the doctors believing they would answer that way. The other high correlation came in response to the statement "Marijuana is harmful to your health" with 68 percent of the public sample agreeing and 67 percent of the doctors believing the public would respond this way.

Public and physicians were also in close agreement with the statement "Physicians should be totally frank and open with their patients about their illnesses," with 88 percent of the public agreeing and 80 percent of the physicians thinking this is how the public would respond.

There was a greater disagreement on the statement "If I had a terminal illness, I would want my physician to tell me" with 93 percent of the public agreeing while physicians guessed that only 69 percent would want to be told the true situation.

Insurance

There were several other items on the survey, one of special interest: 78 percent of the public agreed with the statement that "My health insurance is adequate," while only 44 percent of the physicians thought the public would say this. The public seems more satisfied than doctors think they are.

Demographics

Those surveyed were about equally divided between males and females living throughout Michigan. Thirty two percent were at least high school graduates, 31 percent had some college training and 21 percent were college graduates. The age spread ranged from 12 percent who were under age 25 to 27 percent in the 25-34 age group, 27 percent in the 35-49 group and 33 percent in the over-50 category.

MSMS plans call for copies of the complete survey to be sent to every member and to other professional medical organizations. Copies of the study also will be sent to medical writers in the state and to national publications, together with this review of findings. MSMS will invite inquiries from any source and stands ready to supply more information, if requested.

The MSMS House of Delegates, at its 1981 meeting, reaffirmed the need for a continuing public relations program and called for the organization to continue funds for an on-going study of the public-physician relationship, to the end that better understanding and better medical service will result.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® /5 Buccal mg. /10 Oral mg. /25 Oral mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

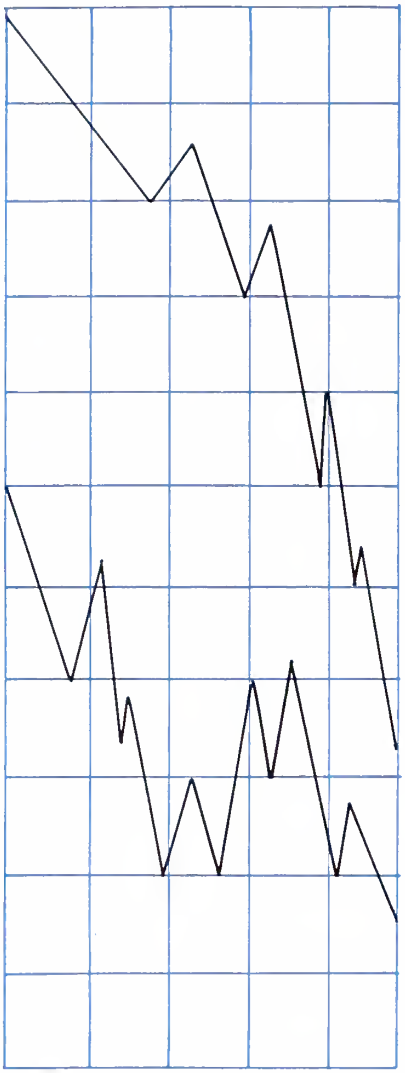
Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Sign up now!

Reagan economist to keynote MSMS Public Affairs Leadership Conference



The Annual MSMS Public Affairs Leadership Conference is being held on October 22, 1981 at the Lansing Hilton Inn, Lansing.

The MSMS House of Delegates challenged MSMS and the medical community to make an aggressive effort to prepare and inform physician leaders. Last year's program featuring Senator Carl Levin and Richard Scammon was a tremendous success.

The 1981 MSMS Public Affairs Leadership Conference will feature Jude Wanniski, supply side economic consultant to Ronald Reagan, and former editorialist for the *Wall Street Journal*, Mr. Wanniski will outline the tremendous national economic policy changes taking place.

Gerald Miller, PhD, director of the Michigan Department of Management and Budget, will candidly discuss the political and fiscal realities of Michigan's budget process.

Check the stimulating program below and register today!

The program

8:30 REGISTRATION

9:30 CALL TO ORDER — Fred E. Patterson, MD, Chairman, MSMS Public Affairs Conference Committee

9:40 OPENING REMARKS — James D. Fryfogle, MD, MSMS President

10:00 "ANTITRUST, HEALTH PROFESSIONS AND MSMS" — William A. Sankbeil, Kerr, Russell and Weber, Detroit

10:30 "THE MICHIGAN BUDGET: FINANCIAL SOLVENCY AND POLITICAL ACCOUNTABILITY" — Gerald H. Miller, PhD, Director, Department of Management and Budget, State of Michigan

11:15 "REAGANOMICS: FROM THE WALL STREET JOURNAL, KEMP-ROTH TO CAPITOL HILL" — Jude Wanniski, President Reagan's Economic Strategist

12:00 LUNCH

1:30 "MSMS: AN AGGRESSIVE ADVOCATE" — Thomas R. Berglund, MD, MSMS Council Chairman

1:45 "AMA BRIEFING: MEDICINES' PRIORITIES" — John J. Coury, MD, AMA Board of Trustees

2:00 "A SUCCESSFUL VOLUNTARY EFFORT — COST CONTAINMENT" — Ruth Gattman, North Central Regional Legislative Chairman, AMA Auxiliary

2:15 "SCOPE AND FUTURE OF THE INDEPENDENT PHYSICIAN" — William R. D. Martin, Dean, School of Management, University of Michigan Dearborn

3:00 "HOW MANY DOCTORS DO WE NEED BY 1995?" — Graduate Medical Education National Advisory Committee (GMENAC) — Robert B. Carbeck, MD, Member of GMENAC Panel, Ann Arbor

3:30 "MEDICINES' OPPORTUNITY UNDER NEW LEADERSHIP" — Ed Annis, MD, Former AMA President

Please return to:

1981 Public Affairs Leadership Conference
Michigan State Medical Society
P.O. Box 950
East Lansing, Michigan 48823

Please print or type.

Name ____________________

Address ____________________

____

Name ____________________

Address ____________________

____

For more information:
Please contact Bill Madigan
or Kevin Kelly
at MSMS Headquarters —
517/337-1351.

Please check one

☐ Physician ☐ Other ____________________

Registration Fee: $25 includes luncheon

Amount enclosed $ ____________________

Please make check payable
to Michigan State Medical Society

There's more to ZYLOPRIM® than (allopurinol).

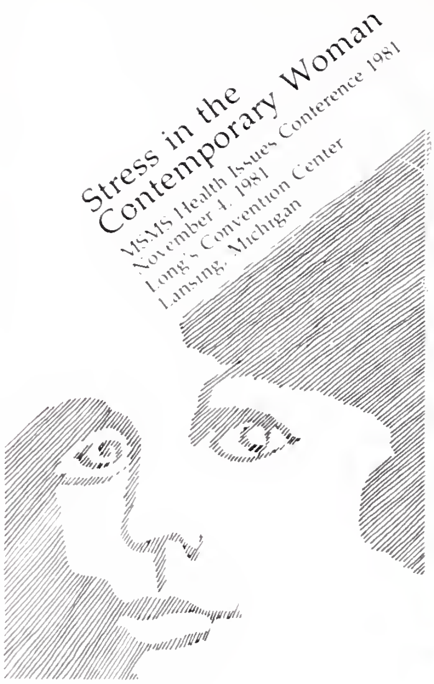
- From Burroughs Wellcome Co. – the discoverer and developer of allopurinol
- Patient starter/conversion kits available for easy titration of initial dosage
- Patient compliance pamphlets available
- Continuing medical education materials available for physicians

Prescribe for your patients as you would for yourself.

Write "D.A.W.," "No Sub," or "Medically Necessary," as your state requires, to make sure your patient receives the original allopurinol.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709


Stress in the Contemporary Woman
MSMS Health Issues Conference 1981
November 4, 1981
Long's Convention Center
Lansing, Michigan

Register today!

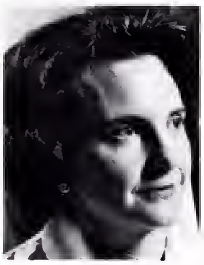
Doctor Adelman

Doctor Eliot

Doctor Logsdon

Doctor McAuliffe

Doctor Pearsall


Doctor Shearer

Doctor Shearer

Registration: Because of limited space, only the first 200 registrations can be accepted.

Program

8:00 **Registration**

9:00 **Welcome**
Marguerite R. Shearer, MD
Conference Chairman

9:15 **Managing 20th Century Stress**
Robert Salim Eliot, MD,
Chairman, Department of Preventive & Stress Medicine
University of Nebraska Medical Center

10:15 **Critical Decision Points in Life**
Kathleen McAuliffe, MD
Family Practice, Lansing
F. Paul Pearsall, PhD
Chief, Problems of Daily Living Clinic
Sinai Hospital of Detroit

Moderators:
Louis R. Zako, MD
Family Practice, Dearborn Hts.
Patricia Leuzzi
Assistant Director
Michigan Women's Commission

11:45 **Luncheon**

12:15 **"In A Man's World — In A Pig's Eye"**
Susan E. Adelman, MD
Surgeon, Southfield

1:00 **Identification & Management of Stress**
Linda J. Logsdon, MD
Psychiatrist, Southfield
Robert Salim Eliot, MD,
Chairman, Department of Preventive & Stress Medicine
University of Nebraska Medical Center

Moderator:
Gerald B. Holzman, MD
Associate Chairman
Dept. of Ob-Gyn & Reproductive Biology,
College of Human Medicine
Michigan State University

2:30 **Break**

2:45 **Reproductive Issues & Sexuality**
Marguerite R. Shearer, MD
Family Practice, Dexter
Marshall L. Shearer, MD
Psychiatrist, Ann Arbor

Moderators:
Thomas R. Berglund, MD
General Practice, Portage
Janice E. Gross, MPH
Chief, State Agency Relationships
Office of Health & Medical Affairs,
State of Michigan

4:45 **Reception**

CATEGORY I CREDIT: As an organization accredited for continuing medical education, the Michigan State Medical Society designates this continuing medical activity as meeting the criteria for 6 credit hours in Category I of the AMA Physician's Recognition Award and the CME requirements of the Michigan Board of Medicine.

This program has been reviewed and is acceptable for 6 Prescribed hours by the American Academy of Family Physicians.

MSMS HEALTH ISSUES CONFERENCE 1981

STRESS IN THE CONTEMPORARY WOMAN
(Enrollment limited to 200)

TUITION: $35 ($15 student)
Send form and check made payable to:

The Michigan State Medical Society
120 West Saginaw
P.O. Box 950
East Lansing, MI 48823

Name (last) (first) (middle initial)

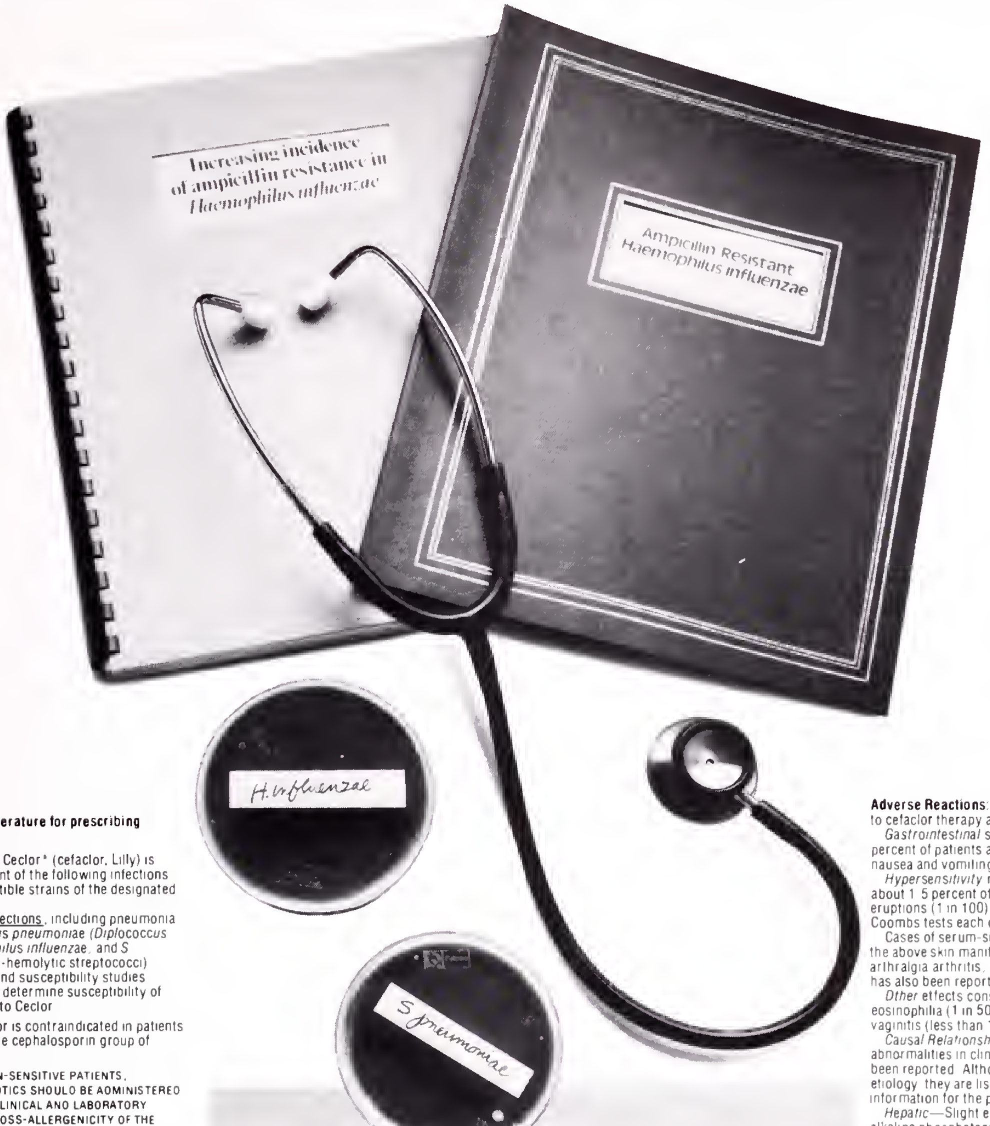
Address (number) (street) (city) (state) (zip code)

Telephone (day) (evening)

Professional Affiliation

Specialty

An added complication... in the treatment of bacterial bronchitis*



Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g, pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [103080R]

---

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae*[8]

Note Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

1 Antimicrob Agents Chemother, *8* 91, 1975
2 Antimicrob Agents Chemother, *11* 470, 1977
3 Antimicrob Agents Chemother, *13* 584, 1978
4 Antimicrob Agents Chemother, *12* 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880 Washington, D C American Society for Microbiology, 1978
6 Antimicrob Agents Chemother, *13* 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr, and J E Bennett), p 487 New York John Wiley & Sons, 1979

Lilly
100061

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina Puerto Rico 00630

Time now to register for Annual Scientific Meeting

Come, get your tickets in hand, Doctor, and join the hundreds of your colleagues planning to attend the 1981 MSMS Annual Scientific Meeting. The big event this year runs Nov. 17-18-19 at the Hyatt Regency Dearborn.

You can register for courses up to the day they take place, but advance registration ensures you get your choice of classes. Hotel reservations must be made by Oct. 26 to take advantage of the special group rates.

So, this is the time to make final arrangements. Here is all the information you need, in summary:

COURSES: There are 57 half-day courses planned on a wide range of medical topics, to help the practicing physician improve care of patients in his or her daily practice.

CREDITS: Each of the 57 courses offers three hours of Category I credit toward the AMA Physician Recognition Award and toward Michigan relicensure. A total of 18 Category I credits may be earned by the physician attending the entire Annual Scientific Meeting.

In addition, all of the courses have been approved to offer either prescribed or elective credits by the American Academy of Family Physicians.

CARDIAC LIFE SUPPORT: Two Basic Cardiac Life Support courses are being offered to physicians at this year's Annual Scientific Meeting. They are scheduled Wednesday and Thursday mornings.

Physicians who enroll in either of these courses will be given first priority for registration in the Advanced Cardiac Life Support course scheduled this year on Dec. 4-5-6 at Lansing Community College. In a departure from previous year's arrangements, the ACLS course is separate this year from the Annual Scientific Meeting. The course will award 16 Category I credits. In addition, candidates who successfully complete the testing according to American Hospital Association standards will be certified as providers in ACLS by the Michigan Heart Association. The course is limited to 48 physicians who have completed the basic cardiac life support course. The fee is $175.

FACULTY: The course directors have organized a faculty of approximately 200 outstanding academic and clinical experts. The faculty members come from a total of 12 states and Canada, with Michigan's finest included. In many cases, the course directors and faculty are those graded best by former Annual Scientific Meeting participants.

FACILITIES: The superlative Hyatt Regency Dearborn hotel is the site of this year's meeting. MSMS meeting rooms, registration desks, exhibit hall and faculty headquarters all are located conveniently in the same wing of the hotel, in the Regency Ballroom area on the first floor, to the left of the entry and just past the hotel registration area.

EXHIBITS: The MSMS exhibit hall, adjacent to classroom areas, will feature 70 commercial and educational exhibits designed to assist the physician in procuring services and products needed in daily practice. The exhibit hall also will be the scene of daily luncheons provided by the hotel and of late afternoon meet-the-faculty "beer busts" sponsored by MSMS.

REGISTRATION: Physicians should register for the Annual Scientific Meeting by filling out the registration form and submitting the fees required. The registration form can be found in the Sept. 11 *Medigram*, the September *Michigan Medicine*, and the second October *Medigram*. Copies are available, as well, from MSMS headquarters.

FEES: The annual Scientific Meeting courses cost $5 per credit hour, or $15 for each half-day course, for MSMS members. Non-members must pay $10 per credit hour, or $30 for each half-day course. The fee for the two-day ACLS course is $175, which includes an American Heart Association CLS text and other study materials. Residents may attend all but the ACLS course for a fee of $5 per course.

LUNCHEON: The Hyatt will provide a luncheon each noon in the MSMS exhibition hall. The registration form asks physicians to indicate which days they would like to take advantage of this special arrangement. Cost of the luncheon each day is $9.

SPECIAL EVENTS: Specialty societies and other groups, including Wayne State University School of Medicine Alumni and Michigan women physicians, are scheduling business meetings, luncheons, receptions and dinners during the Annual Scientific Meeting. In addition, alumni from each of the state's medical schools will be special hosts for the coffee breaks and beer busts.

COMMITTEE IN CHARGE: The MSMS Annual Scientific Meeting Task Force is directing the organization of the 1981 MSMS Annual Scientific Meeting. Frank Cox, MD, Detroit, director of the Office of Continuing Medical Education at Henry Ford Hospital, is chairman. Doctor Cox's committee has worked for more than a year to plan the event, contacting the state's medical schools and all its specialty societies to invite them to sponsor courses. The task force falls under the aegis of the MSMS CME Programming Committee, led by Samuel M. McMahon, MD, Lansing.

PAIN AND TENSION...
Double fault for
weekend warriors
ACE THE ACHE
with

Equagesic® (IV)

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

***INDICATIONS**: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information FDA has classified the indications as follows

'Possibly' effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use, i e more than four months has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination

USAGE IN PREGNANCY AND LACTATION: **An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug**

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia or visual disturbance occur, the dose should be reduced If symptoms continue patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken sleep ensues rapidly and blood pressure pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g caffeine Metrazol or amphetamine may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia this symptom can usually be controlled by decreasing the dose but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely may also have other allergic responses, including fever fainting spells angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine antihistamine and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia In nearly every instance reported other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness with uneventful recovery However, on the basis of pharmacological data it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate 75 mg ethoheptazine citrate and 250 mg aspirin

Copyright © 1981, Wyeth Laboratories
All rights reserved

*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101
TM

Down with pain
Step up to reliable relief

for mild to moderate pain

Wygesic® Ⓘⓥ

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary

INDICATION For the relief of mild-to-moderate pain

CONTRAINDICATION Hypersensitivity to propoxyphene or to acetaminophen

WARNINGS CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol tranquilizers sedative-hypnotics or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts as well as misuse of tranquilizers alcohol or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

USAGE IN AMBULATORY PATIENTS Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks e g driving a car or operating machinery Patients should be cautioned accordingly

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore propoxyphene should not be used in pregnant women unless in the judgement of the physician the potential benefits outweigh the possible hazards

USAGE IN CHILDREN Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group

PRECAUTIONS: Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants including alcohol

ADVERSE REACTIONS The most frequent adverse reactions are dizziness sedation nausea and vomiting These seem more prominent in ambulatory than in nonambulatory patients some of these reactions may be alleviated if the patient lies down

Other adverse reactions include constipation abdominal pain skin rashes light-headedness headache weakness euphoria dysphoria and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported

DRUG INTERACTIONS Propoxyphene in combination with alcohol tranquilizers sedative-hypnotics and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine

MANAGEMENT OF OVERDOSAGE SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma pupillary constriction. and circulatory collapse In addition to these characteristics which are reversed by narcotic antagonists such as naloxone there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported and apnea cardiac arrest and death have occurred

Symptoms of massive overdosage with acetaminophen may include nausea vomiting anorexia and abdominal pain beginning shortly after ingestion and lasting for 12 to 24 hours However early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill; however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity jaundice coagulation defects hypoglycemia encephalopathy coma and death may follow Renal failure due to tubular necrosis and myocardiopathy have also been reported

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists naloxone nalorphine and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered preferably I V simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions

Oxygen IV fluids vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia nausea vomiting and drowsiness Appropriate literature should be consulted for further information (JAMA 237 2406-2407 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

Copyright © 1981, Wyeth Laboratories.
All rights reserved

Wyeth Laboratories
Philadelphia, PA 19101

Health education comes into own just as funds shrink away

By Martha Boyce, special to Michigan Medicine

Don E. Coleman, PhD, left, president of the Michigan Health Council, visits with William Carlyon, PhD. Doctor Carlyon, director of the AMA Department of Health Education, discussed disease prevention and health promotion at an MHC task force meeting in East Lansing.

Is there a difference between disease prevention and health promotion? Are we trying to attain "high level wellness" or merely trying to prevent cancer and heart disease? These are challenging questions for health educators posed by William Carlyon, PhD, Director of the AMA Department of Health Education. Doctor Carlyon was the principal speaker at a Michigan Health Council task force meeting at MSMS headquarters in mid-summer.

Doctor Carlyon said he believes there is a difference between high level wellness and disease prevention. He said that high level wellness includes the philosophical and spiritual side of life. Eliminating prejudice and other harmful social attitudes can enhance the health of individuals and society as a whole. The negative effects of stress on health have been proven. Some doctors are using a more holistic approach in their practice now, while others continue to see themselves as "bioengineers," treating and preventing disease. Doctor Carlyon believes there is room and a need for both philosophies.

AMA program

Doctor Carlyon pointed out that the AMA has included health education in its program since its formation. The original AMA joint committee with the NEA was replaced by the Medicine/Education Committee on Schools and Colleges. There are a total of 17 medical and educational organizations represented on the committee. Their major activity for the coming year is to publish a much-needed school health policy.

The Health Education Department of the AMA has served as a clearinghouse in two major areas:

1. To provide information on health and disease.
2. To be a consultation service for national organizations and to assist state and local medical societies.

The Health Education Division specializes in several projects each year. This year there are three major projects:

(1) Biotelecommunication — Due to the technical revolution, the AMA is especially interested in how health information will reach people in the future. Cable franchises are being established across the country and are hungry for programming ideas to fill their multiple channels. The AMA is considering developing a health channel. A national physician celebrity is launching such a channel of his own.

(2) Cross-Cultural Patient Health Education — Most of the medical practice in this country is Anglo/Western in its approach. Doctor Carlyon stated that Hispanics are the fastest growing minority, and that their views on health and disease often conflict with that approach. The AMA seeks to determine what problems exist so that doctors may better serve this community.

(3) Patient/Physician Education on Specific Topics — A slide/tape program is being prepared which describes how to benefit most from a visit to a doctor. Patients can prepare ahead of time by making a list of pertinent questions, for example.

A program on smoking is also being developed, as well as a guide for physicians on behavior modification.

Challenges coming

Doctor Carlyon noted several challenges in the coming year for health educators and health promoters.

The first problem is obtaining sufficient funds. It seems as though health education came into its own just when the funds shrank away. Health educators are needed in many areas, but there is a problem in finding enough jobs for them.

He said we need to clarify our goals — health education has caught on, but we must be careful in what we can accomplish. He discouraged the use of "jazzy" terms such as "health prevention" and "self prevention" which obviously have the wrong connotations.

There is a great need for follow-up on doctors' recommendations. When a patient is advised to quit smoking, for example, he or she often needs resources and support from the community. This is a vital function for health organizations to assume.

Doctor Carlyon suggested people need to be left alone, some, too. They have some rights to privacy. There is room for fat people and smokers, he said. He warned against relying too heavily on numbers, and on promised longevity. Young people are especially interested in the quality of life now; not necessarily in the number of years they can expect to live.

It's so simple, at first you may not understand It.

F 5 8
4
RATE-COUNT
CATEGORY
DART MEDICAL
ON
OFF
MEMORY
PLAYBACK
PROFILE
Criterion II™
RHYTHM PROFILE MONITOR
CHARGING

Criterion II™

RHYTHM PROFILE MONITOR

For the patient, it is almost as simple as looking at his watch. For the physician, it is almost as good as being there. For the health care system, it may be the most cost-effective monitoring approach ever. The RPM is a versatile, counting, catagorizing, remembering, communicating machine.

Transient symptomatic events and significant asymptomatic irregularities can be sent in real time or from memory as a quality EKG to any compatible receiver.

It is really

great for arrhythmia documentation

Being portable the monitor is especially convenient for extended periods of use. Patient captured symptomatic arrhythmias as well as profile indicated asymptomatic EKGs can be transmitted for prompt evaluation by the physician.

even better for post m.i. surveillance

The unit's unique profiling concept allows for individualized monitoring programs including remote EKG transmissions if desirable. Trends and longer term dysrhythmic activities become apparent to the clinician with the aid of a patient maintained Profile Log.

the best for drug management

Now the physician can more precisely know how changed medications and dosage levels are affecting a patient. Trends in suppression or toxicity are quickly evident because significant irregularities can be transmitted as they occur for clinical assessment.

For your personal demonstration, visit us at Booth 511 during the MSMS Scientific Meeting November 17-19, 1981.

500 Hogsback Road, P.O. Box 212, Mason, MI 48854
Telephone (517) 676-5533

DART MEDICAL

Here is text of MDs', DOs' proposal for new Medicaid utilization system

The article on the following pages is part of a report which took hundreds of hours of work by Michigan MDs and DOs during the summer months of 1981.

The article presents significant parts of the physicians' proposal for an alternative utilization system for the state's Medicaid system. MDs and DOs were ordered by PA 35 of 1981 to propose the alternative system to help the Medicaid system survive the state's deep financial problems.

MSMS and the Michigan Association of Osteopathic Physicians and Surgeons brought their Medicaid Liaison Committees together, led by MSMS committee chairman Allen F. Turcke, MD, and MAOPS committee chairman William O. Anderson, DO. They hammered out their joint proposal by the Aug. 7 deadlines set by the state.

They did a good job, as evidenced by the reactions of the Senate and House committees now studying the proposal.

". . . the proposal makes a major step in the direction of an alternative Medicaid reimbursement system for physicians," responded Stephen V. Monsma, chairman, Senate Appropriations Sub-Committee on Social Services.

"I am greatly encouraged by the cooperative perspective of the draft and am confident that by continuing to work with your association and the Department (of Social Services), that the particulars of an equitable scheme can be developed."

House Appropriations Subcommittee on Social Services Chairman David C. Hollister wrote, "You took upon yourselves a difficult and complex task and have produced a proposal which should prove the basis of what I hope will be some innovative medical programs for the Medicaid population."

Rep. Hollister cited the physicians "hard work and creative effort."

The legislature was still considering the plan it mandated of Michigan MDs and DOs to negotiate at the time this issue went to press; final word was not received. The plan was supposed to go into effect on Oct. 1.

To familiarize all MSMS members with the proposal worked out by their Medicaid Liaison Committee members, here are pertinent parts:

Physicians' Proposal

- Medicaid eligibles shall select a primary sponsor (control physician or provider) of choice, provided the sponsor agrees to accept the recipient. Either party wishing to terminate the arrangement may do so upon reasonable notice and for justifiable cause (to be defined). The Department of Social Services shall notify each primary sponsor of his/her/its assigned patients for the coming month no later than three days prior to the beginning of said month.
- Medicaid eligibles shall be given 60 days from the beginning of the enrollment period to voluntarily select their primary sponsor. A plan shall be developed jointly by MDSS, MAOP&S and MSMS for enrolling eligibles who have not selected a primary sponsor after 60 days.
- In recognition of the additional services required of the primary sponsor (continuous responsibility, accessibility, the process of control, preauthorization of services, cost constraints), incentive administrative fees shall be authorized. The actual amount and process by which it is rendered to the primary sponsor shall be the subject of additional discussions among MDSS, MAOP&S and MSMS.
- Each physician contact by the recipient shall be paid on a fee-for-service basis structured to discourage over-utilization. Examples of incentives shall be:

1. Parity reimbursements for ambulatory services regardless of setting. In particular, total reimbursement for *hospital freestanding* clinic services shall not exceed comparable office-based services.
2. Higher reimbursement for office-based surgical procedures.

- All physicians enrolled as participating physicians in the Medicaid program shall be eligible for participation in this program. MDSS should monitor primary sponsors enrolled in this program and clarify its authority to act expeditiously to disenroll any physician abusing the program.
- This program is recommended on a pilot basis. Targeted areas shall contain a significant Medicaid population and participating physicians so as to obtain a representative cross section of sick and healthy eligibles.

Particulars and priorities

The MSMS/MAOPS task force has identified several priority issues which must be considered a part of the Physicians' Proposal for Utilization Management. Indeed, we believe they must be considered regardless of whether this or another approach is taken toward an alternative reimbursement system for Medicaid.

1. **Educational responsibilities.** Medicaid recipients must be informed, in plain language, that their medical benefit package is threatened by the state's economic plight. This should be the responsibility of MDSS.

Physicians must be informed that sufficient participation in the recipient lock-in plan is necessary to determine its potential effectiveness. This is the responsibility of MSMS and MAOPS.

2. **Parity of Medicaid with Medicare.** Ideally, physicians should receive the same reimbursement for services rendered regardless of the source of payment, i.e., private, Blues, Aetna, HMO, or the government.

Realistically, Michigan physicians have only asked that two government programs (Medicare and

continued on page 534

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN

Healthy Competition
Makes A Healthier Market

Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.

Occurrence Coverage

Choice of limits— $100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

Medicaid) designed to assist our elderly, disabled, and our poor be equitable in reimbursements. The only possible reason Medicaid physician participation has not been drastically reduced since December is that physicians are aware of the State's economic situation and are attempting to absorb their fair share of the necessary budgetary cuts.

The question is how long physicians can continue to exist with the disparity between Medicaid and Medicare? The disparity in 1976, when the State approached a crisis situation in physician participation in Medicaid, was 27 percent. Now, in mid-1981, Medicaid payments are 45 percent lower than Medicare levels. This disparity will increase after July 1 when Medicare screens are traditionally updated to reflect the previous year's data. To phrase the situation another way, assume a physician's regular charges are paid by private-pay or other insurance at 100 percent. Medicare usually reimburses at 75 percent of charges; now Medicaid reimburses at 55 percent of Medicare. Physicians are asking that Medicare screens be used as the minimum standard.

3. **Primary sponsor.** Under the proposal, a primary sponsor shall accept the full responsibility for rendering or authorizing all care for that Medicaid recipient. The primary sponsor would have to arrange coverage with another physician while absent from the community. A pharmacy could only fill a prescription on the primary sponsor's authorization. An emergency room would have to receive authorization from the primary sponsor prior to rendering non-emergent care.

A primary sponsor could be an individual physician, a group practice, a clinic, or an institution. The setting must be one which the recipient has chosen and which has control of the patient chart. In a clinic setting for example, a recipient may request services and be seen by alternate physicians, but the chart would serve to indicate whether duplicate or unnecessary services would result.

The Department of Social Services should carefully monitor all primary sponsors. Where costs are considered excessive, recipients should be directed to other sponsors for diagnosis and treatment.

Note: This redirection of services is a difficult problem. MDSS, the participating physicians and other sponsors must recognize the problems inherent in distinguishing between utilization versus over-utilization, quality versus quantity and the dilemma of health care rationing. We must work together in good faith to neither abuse the patients nor the system. We also should not be constrained by rules and regulations that interfere with our collective best judgment in direction recipients for appropriate care.

4. **Referral care authorized by primary sponsor.** In addition to the requirement that all referral care be authorized by the primary sponsor, MDSS should provide the primary sponsor with a list of all referral services received by each recipient in his/her/its control. Frequency of reports can be determined in cooperation with MDSS analysis of ability to generate reports. The referral care reports would serve as an informational/educational vehicle for the primary sponsor.

5. **Office-based surgical procedures.** The MSMS/MAOPS task force strongly believes that physicians should be encouraged to perform selected surgical procedures in the least expensive setting. We recognize that this concept has been accepted and implemented, to a limited extent, in differential reimbursements for in-patient and out-patient settings. Now we believe it is time to go another step in order to decrease the facility costs associated with traditional out-patient/ambulatory procedures conducted in institutional settings.

The Department of Social Services, in conjunction with physician associations, PSROs, and others have developed a tentative list of selected procedures which could serve as the basis for discussion. Careful analysis of appropriate procedures would be required along with estimates of reasonable costs to physicians in recognition of additional equipment, personnel and facility changes which may be necessary to assure quality of care. Since office-based surgery would eliminate costs generated by out-patient surgeries (surgical suite costs, recovery room costs and fixed-day costs), we recommend a 25 percent increased fee above updated screens for those procedures when they are done in the physician's private office.

6. **Reimbursement for primary sponsor responsibilities.** The MSMS/MAOPS task force devoted many hours in an attempt to develop equitable financial recognition of the additional responsibilities that will be required of a primary sponsor. In addition to the medical responsibilities such as 24-hour accessibility, there certainly will be additional administrative costs incurred for such things as referral authorization forms.

The approach recommended by the task force is a fixed fee paid to the primary sponsor per assigned Medicaid eligible per month. Suggestions have ranged from \$3 to \$7 per month. This administrative service fee would recognize those situations where the primary sponsor exercises control of recipient care although an actual physician/patient encounter may not occur, such as when the sponsor makes telephone calls authorizing or refusing referral care, or refuses patients emergency room services at night for non-emergent conditions.

The MSMS/MAOPS task force has not reached a decision on the most appropriate financial incentive to recognize the additional responsibilities of a primary sponsor. We realize the incentive funds identified by the Legislature amount to only \$6 million and our first priority is to update Medicaid screens. However, if the proposal eliminates duplicative physician services and decreases emergency room visits, an equitable administrative fee does not seem unreasonable. Additionally, since the proposal is recommended for targeted areas on a demonstration basis, the number of eligibles/administrative fees will be significantly less than if it were a statewide program.

7. **"Lock-in" is necessary for recipient over-utilizers.** The MDSS methodology for currently identifying Medicaid recipients who over-utilize the program has been transmitted to MSMS and MAOPS, but needs further explanation, clarification and simplification. The criteria

MEDICAL SERVICES ADMINISTRATION

©1979 MDSS

used to define "over-utilization" need to be tightened or lowered. For instance, the MDSS practice of using 60 scripts per month as the threshold for pharmacy over-utilization seems rather high.

After more appropriate criteria are developed for identifying recipient over-utilizers, recipients so identified should be required to obtain a primary sponsor. They would have choice of sponsor and the sponsor would have a choice of acceptance. We would recommend for this particular group of recipients that the primary sponsor be a private practitioner in conjunction with a specific pharmacy.

8. **Fraud and abuse activities.** Although it has been stated before by both MSMS and MAOPS, the task force wishes to reiterate its strong support for MDSS activities to identify suspected cases of physician abuse of the Medicaid program and to instigate administrative sanctions against those with demonstrated patterns of abuse. If problems exist with the recent legislation (PA 321 of 1980) designed to strengthen the department's ability in this regard, they should be brought to our attention so appropriate amendments can be sought.

9. **Retention of fee-for-service.** The MSMS/MAOPS task force seriously considered other ideas brought to its attention by MDSS and other interested parties. We cannot agree to a "capitation" for the entire Medicaid program. That approach is being used in several models at the current time and can be used for future comparisons with the proposed fee-for-service "lock-in" approach presented herein.

10. **Pilot projects in different geographical areas.** The task force recommends that the proposal be used as a demonstration project in more than one area to account for differing population characteristics. For example, perhaps Wayne County, Bay County and Muskegon County would offer interesting comparisons. Information on how the program affected utilization in each of the sites would need to be carefully monitored and reported for meaningful comparisons.

11. **"Key" to the lock.** The task force believes it is important to guarantee an equitable process whereby eligibles and sponsors alike can terminate the lock-in agreement. The "key" must be reasonable for the MDSS to administer and provide timely notices to all parties. Regardless of the final process developed it must assure that requests for reassignment are not based solely on the basis of race, color, creed, marital status, sex, national origin, residence, age, or handicap.

Purpose and projections

The purpose of the Physicians' Proposal for Utilization Management is to conduct an experimental alternative reimbursement system for physicians under Medicaid through an approach which locks in recipients with a primary sponsor. It should be a pilot project in a significant geographical area containing a significant number of Medicaid eligibles representing a cross section of healthy and sick recipients and a significant number of enrolled physicians. The pilot program should have a defined trial period to enable comparisons to be drawn among the existing reimbursement systems.

The proposal is designed to determine whether the Michigan Medicaid program can experience financial savings through reductions in hospital costs and in physician service duplications using a physician/patient "lock-in."

We believe this proposal complements the goals of the Michigan Hospital Association's plan to reduce hospital utilization by approximately 12.6 percent at an anticipated savings of $35 million. We are unable to estimate cost-savings from our proposal until the scope of the pilot areas has been determined. It should be noted that projected cost-savings cannot be derived simply from the physician line item account because all other medical services accounts will be affected. We project savings not only in physician utilization, but in hospital admissions, hospital utilization, pharmaceutical services, emergency room utilization for non-emergent care, and non-emergent ambulance utilization.

We sincerely hope and believe that our proposal will be cost-effective. But, and more importantly, we hope that the prime consideration will be whether quality medical care is delivered to the Medicaid population of our state. If cost considerations outweigh quality of medical care, then it is our opinion that many people have labored in search of a

MEDICAID/*continued*

short-term solution without looking at the long-term problem.

Proposals for long range solutions

The proposals made in the previous section will only be effective in the long run if certain additional changes are made in the Medicaid program. These changes are viewed as major structural modifications in the program and are too extensive to be accomplished within the time limits imposed by the present legislation. They should be viewed as forming the basis of future discussion between MSMS, MAOPS, the Michigan Department of Social Services and the Legislature.

From the physician perspective, these structural changes are necessary because those programs which only focus on provider reimbursement have a very limited potential for creating real, permanent cost savings.

The MSMS/MAOPS task force would like to make the following suggestions for topics to be discussed in the future:

a. Instead of budgeting by provider class, e.g. physicians, hospital, pharmacy, the Medicaid program should be budgeted by recipient programs viz. AFDC, SSI, and medically needy.
b. Prioritizing the type of benefits paid for under the program.
c. Defining and limiting the benefits offered under the Medicaid program.

Change the basis of budgeting from the providers of service to the recipient program classification. The Medicaid program has at least three distinct groups of recipients: the AFDC and general assistance population, those individuals receiving supplemental security income aid from the federal government, and the medically needy. Each of these groups has separate medical needs and utilization characteristics. By placing them all under the single line item of Medicaid and then making allocation by medical provider, the potential for cost saving in any one program is obscured. Additionally, by budgeting in this manner it becomes much easier to blame the providers of services for the financial shortfalls.

From the information supplied to the task force by the MDSS, amount of per recipient benefit increased very little between 1974 and 1979 ($622 to $641) in CONSTANT DOLLARS.

The real problem facing the Legislature is inflation, and the need to control the apparent increase in dollars allocated to the Medicaid program.

The physicians of the State recognize this as a very difficult situation, but one over which they have very little control. By continuously reducing the fees paid to providers, the Legislature is only avoiding the public policy decision of how to allocate resources to needy groups

continued on page 538

Doctor Black leads Wayne County Society

Robert W. Black, MD, an internist, is the president of the Wayne County Medical Society (WCMS). He was installed in ceremonies at the 31st annual meeting of the WCMS, June 1, succeeding Kenneth J. Ray, MD as president of the 3,500 physician member organization.

Doctor Black has been chief-of-staff at Harper-Grace Hospitals since 1976 and was chief-of-staff of Harper Hospital from 1972-1976. He continues a private practice in internal medicine from offices in the David Whitney Building in Detroit.

A member to the WCMS Council (governing body) since 1971, Doctor Black also has served as a delegate to the Michigan State Medical Society (MSMS) from Wayne County during that same period. During 1979-80 year he was WCMS Secretary.

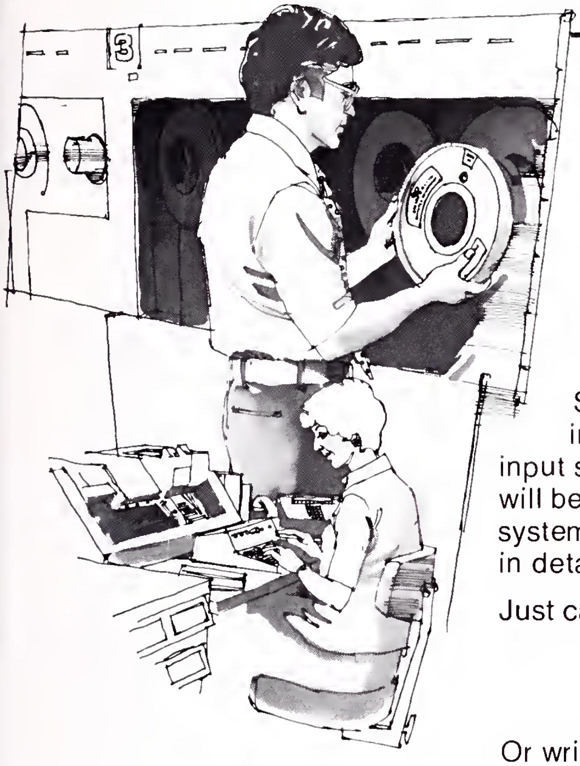
In addition to many WCMS and MSMS committee appointments, Doctor Black has been on the Blue Cross Blue Shield of Michigan Board of Directors and Professional Relations Committee since 1976. He has held numerous positions at Harper-Grace Hospital and has been a clinical associate professor in the Department of Medicine at Wayne State University School of Medicine since 1978.

Doctor Black received his MD degree from McGill University, Montreal, in 1948. He interned at Montreal General, and served his residency at Queen Mary Veterans Hospital (Montreal) and Harper Hospital (Detroit).

His memberships include the Detroit Medical Club, Academy of Medicine, and the American College of Physicians.

Doctor Black and his family are residents of Grosse Pointe.

Use automated input to cut your paperwork, speed up claims payment



Whether you have your own computer or are working with a service bureau, and especially if you are still processing all your claims manually, the Blue Cross and Blue Shield of Michigan Automated Input System is worth looking into. Our automated input staff representatives will be pleased to explain the system's many advantages in detail.

Just call:
313-225-0056
313-225-0039
313-225-0042

Or write:
Blue Cross and Blue Shield of Michigan
Automated Input Department J308
600 Lafayette East
Detroit, Michigan 48226

It's good to belong.

Blue Cross
Blue Shield
of Michigan

"See you at Booth #504 at the MSMS Annual Scientific Meeting!"

within our society during times of extreme inflation.

In order to focus on this problem, it is apparent that at some point public policy must consider the relative merits of limiting services to certain types of individuals to insure every individual in need will receive at least adequate medical care.

A second benefit to identifying each group separately within the Medicaid program will be the ability to create specific cost containment programs suitable to the medical needs of these groups.

Data from the MDSS and other sources indicate substantial differences between the utilization pattern of the AFDC population as compared to the medically needy group. The AFDC group is very similar to the general population in use and intensity of service and possibly programs such as pre-payment or indemnification could be used to cover this population. However, the data indicates the medically needy recipients are individuals with extensive need for medical care. Many individuals in this group are permanent institutionalized patients, and would require completely different and creative types of cost containment programs.

Prioritizing the types of benefits offered. The federal government requires a state Medicaid program to provide for payment to hospitals and physicians in order to be eligible for matching funds. Along with these services the states have the option of covering additional types of services. It is not our intention to discuss the relative merits of offering these programs. We propose that the decision to offer these services be made each year and be dependent on the state's ability to pay for them adequately. If the Legislature believes it should make these programs available, then it must be prepared to fund them at a level approaching the actual value of the services.

When the state is not economically able to cover the expanded benefit categories, the Legislature, with the advice of the medical community, must determine which services will be of the most assistance to the recipient population and formulate policy accordingly.

Defining and limiting the benefits offered under the Medicaid program. The Medicaid program in Michigan has been referred to as the best health insurance program available in the world today. The Legislature, with the assistance of the physicians, must determine which benefits are most necessary to maintain the health of the recipient population and determine the quantity of those services necessary to accomplish this goal.

It is apparent as the program is presently structured, neither the providers of services nor the recipients have any real initiative to make decisions regarding the most effective utilization of services.

A number of states are presently studying proposals to bring the Medicaid coverage more in line with the commercial insurance or prepaid health plans available in their states.

It is our understanding the MDSS is currently studying several proposals from HMOs to cover Medicaid recipients and each of these proposals contains definite limits on certain services.

Congress presently has before it several proposals containing provisions to limit the type and quality of services available under the program. We recognize the concept of limiting the benefit package must be approached very cautiously.

The basic provision of the Medicaid program is to provide for the medical needs of the poor. Unfortunately, in today's economy this goal will be unattainbable unless some system is developed to determine which benefits will have the most impact on the health of the population and how much of each service can be made available to any particular recipient. The only alternative is to ration care based on the amount of dollars available regardless of how important some of these procedures are to the over-all welfare of the individuals.

The limiting of services available to any one individual can not be taken lightly. There always exists the possibility that if limits are placed on the number of services a recipient may receive, we may be denying needed medical care. We are confident a suitable system can be designed to allow for catastrophic illness and the accompanying need for extensive utilization of services. This sytem can be designed in a way which would place the least burden on the recipient and the provider, insuring the patient will receive medical care without interruption.

These three basic proposals, plus specific ideas suggested earlier in this paper, create the basis to begin developing permanent solutions to the cost of providing care to the Medicaid population. The task force feels any solution to the present difficulties must include both the specific short term adjustments to the program and the long term changes suggested in this section.

All of the above proposals must be addressed in order for MSMS and MAOPS to feel confident in endorsing any plan eventually presented to the legislature by the MDSS.

We will offer the assistance of each of the associations in developing a time schedule to develop specific proposals to implement both the short and long term goals presented in this paper.

New JCAH Accreditation Manual Out

The Joint Commission on Accreditation of Hospitals (JCAH) recently published the 1982 edition of the *Accreditation Manual for Hospitals (AMH)*.

The *AMH* features general administrative policies and procedures governing accreditation surveys, a statement of patient rights and responsibilities, standards covering 24 key areas of a hospital's operations, and an appendix that describes all differences between the 1981 and 1982 standards.

Companion volumes of the *PHAS Manual* (8th edition) and *Hospital Survey Profile* also are available. Hospitals accredited by JCAH receive a complimentary copy of the *AMH*.

Physicians interested in more information on the *AMH*, its companion volumes, or *JCAH Perspectives*, or who wish to order copies, may contact the Department of Publications, JCAH, 875 N. Michigan Avenue, Chicago, 60611.

Put us to the test.

Send us a split specimen—at our expense—we'll prove our accuracy.

First, establish an account with us. It won't cost you anything. Then at your convenience, draw a specimen using accepted procedures. Divide it and submit it under two names. When you receive the results, and you're satisfied they're statistically parallel, call us. We'll credit your account. It's that simple.

What else can you expect?

Quick results. We have three strategically located labs to provide routine test results within 24 hours, tissue results within 48 hours. Plus STAT service on some procedures.

Pickup and mail service. In many areas, our trained couriers will pick up your specimens. Outside our wide service areas, we provide prepaid mailing containers.

Quick-scan highlighted reports. Our reports were designed by pathologists. Abnormals are highlighted, making them easy to spot.

Staff pathologists. Abnormals are reviewed daily by our full-time staff pathologists. Any significant abnormal is immediately retested at no charge and the confirmed results phoned to you. Of course, our pathologists are available for consultation at any time.

Serum retention program. To make it easier for both you and your patient, every serum specimen is frozen for one week after initial testing. If further testing is necessary, just call us.

Accuracy assistance. We can assist you in training your personnel in laboratory procedures and proper specimen handling. Proper collection, handling and submission at your end further ensures accuracy at ours.

We're CBC and we've got a lot more to offer you. Our service is comprehensive, convenient, fast, and most important . . . accurate. Take the time to take our test. It may be one of the best things you ever do for your patients. And we *can* prove it.

To put us to the test call:
1-800-632-0706.

CBC CONTINENTAL
BIO-CLINICAL
LABORATORY SERVICE, INC.
Grand Rapids, Michigan • Toledo, Ohio
Mishawaka, Indiana

New federal tax laws may make your estate plan obsolete

By Thomas L. Geer, Esq., Troy

The Reagan tax legislation, the Economic Recovery Tax Act of 1981 (ERTA), as finally passed by Congress, contains significant changes in a number of different areas. One area of change with immediate impact on physicians is in the transfer taxes. By 1986, almost all estates will be exempt from taxes. This column discusses the estate and gift tax changes made by ERTA and their impact on the estate planning by physicians.

Increase in unified credit

The most dramatic change made by ERTA was an increase in the "unified credit." This is a credit against estate and gift taxes which eliminates gifts and estates of less than a certain amount from taxation. For 1981, the exempted amount was $175,025. Starting in 1986 estates of less than $600,000 will be exempt from all taxes.

This change has been viewed by some as eliminating the need for tax-oriented estate planning. This is not, however, true for most persons of moderate wealth. The $600,000 "exemption" in 1986, even assuming a modest inflation rate of 7 percent per year, will only cover $428,000 in 1981 currency. Since the credit increases stop in 1986, inflation will continue to eat into the value of the exemption as time passes.

Since many physicians have assets worth over $428,000, taking into account investments, insurance, pension plans, houses, offices, and the value of the physicians' practices, this increase in the unified credit is illusory.

One effect which the increased exemption will clearly have on physician's estate planning is to increase the use of "equalization clauses" and "reduce-to-zero clauses" in marital deduction planning. An equalization clause equalizes the estates of both spouses to minimize the overall tax burden. A reduce-to-zero clause overrides the normal marital deduction clause, when a lesser amount would reduce the estate tax on the death of the first spouse to zero.

Combining these two clauses minimizes the overall tax burden. For example, assume Doctor Smith died in 1986, with an estate of $1,000,000 and Mrs. Smith had assets worth $350,000. The equalization clause would give $325,000 to Mrs. Smith, equalizing both estates at $675,000, and the other $675,000 would go into a family trust. If Doctor Smith were worth only $800,000, the reduce-to-zero clause would give Mrs. Smith only $200,000, reducing Doctor Smith's estate to $600,000 (with no taxes payable) and leaving Mrs. Smith with $550,000. This would permit some growth for Mrs. Smith without incurring taxes on her death.

Unlimited marital deduction

The second change in ERTA is the unlimited estate tax marital deduction. Before ERTA, only half a decedent's estate could be deducted as a marital deduction, but ERTA has removed this limit completely. Thus, in our first example, Doctor Smith could have given Mrs. Smith $1,000,000, and deducted the entire amount. The question here is why he would want to do that since he does not need to.

By giving Mrs. Smith only $400,000, Doctor Smith reduces his estate taxes to zero, and, on Mrs Smith's death she pays a tax of only $58,500 on the $750,000 in her estate. Giving all $1,000,000 to Mrs Smith would increase her death taxes to $335,000, for no good reason. Of course, the lowest taxes are paid under the equalization clause since it always minimizes overall taxes.

Lowered maximum rate

The maximum rate of the transfer taxes will be gradually decreased from 70 percent of the excess over $5,000,000 to 50 percent of the excess over $2,500,000. While this will decrease taxes significantly for the wealthy (remember that this is only $1,783,000 in today's dollars) it will not change tax planning significantly. Fifty percent is simply too high a tax rate not to avoid by proper planning.

Gift tax changes

These changes affect gift tax planning. The narrowest of these three is the removal of gifts for tuition and medical expenses from the gift tax entirely, which will remove uncertainties which have previously existed in the support of adult children.

The annual exemption now allows gifts of up to $3,000 ($6,000 for a married couple) per year before any part of the unified credit is used. Beginning in 1982, this will be increased to $10,000, ($20,000 for a married donor per year.) This means that a married physician with four children could give $80,000 away in 1982 to his children, or to trusts set up for them, without any adverse transfer tax effects.

The second major change in the

gift tax is the unlimited marital deduction, whose value in estate tax planning was discussed earlier in this column. In gift tax planning, however, the unlimited marital deduction can be used to handle the "wrong order of death" problem. Normally, the working spouse is worth considerably more than the other. The couple's estate plan may work very smoothly if, as expected, the working spouse dies first, since an equalization clause will minimize the taxes. Problems arise, however, if the other spouse dies first, because the estates cannot then be equalized and the overall tax burden will be larger. In our example, if Mrs. Smith died first and all her assets went into a family trust, her $350,000 would not be taxed when Dr. Smith dies, however, his $1,000,000 estates would pay $190,000 in estate taxes. Now, however, this problem can be solved, as long as the richer spouse has confidence in the stability of the marriage. If Doctor Smith gives Mrs. Smith $325,000, it does not matter who dies first since they will each have assets of $675,000. This can be done immediately before the nonworking spouse dies.

Summary

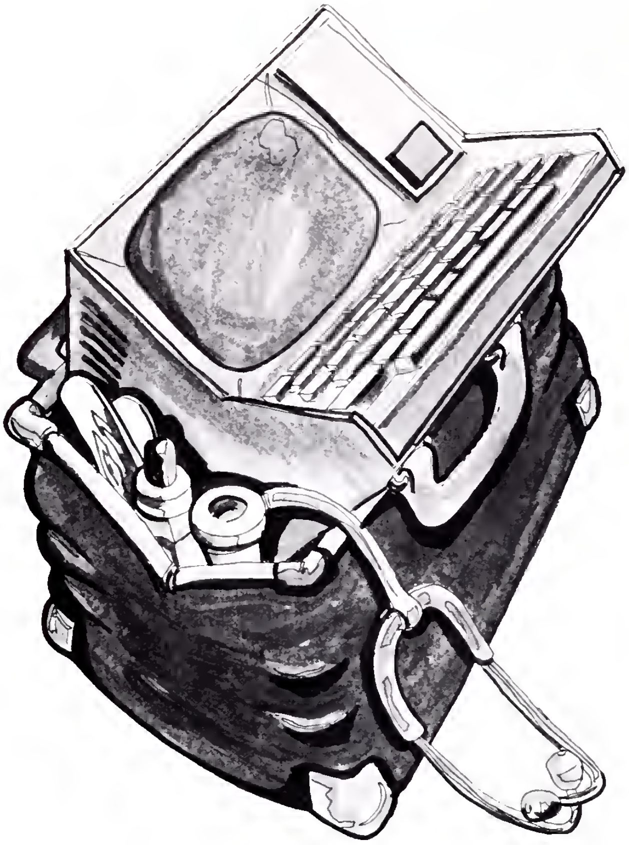
ERTA made important changes in the estate and gift taxes. These changes have rendered many existing estate plans obsolete, but careful attention must still be given to the tax aspects of estate planning. Anyone concerned about his estate and the financial fates of those who survive him or her should therefore review his or her estate plan with a qualified tax adviser.

The Eye's Anatomy
eing

Flint-area ophthalmologists recently installed a new eye exhibit, above, as a permanent display in the Flint Institute of Health. This exhibit was organized by Fleming Barbour, MD, with assistance of other ophthalmologists of the Genesee County Medical Society. The ophthalmologists helped plan and design the exhibit, which was built by a Chicago studio. Through graphics, models and audience participation, the exhibit creates an awareness of the importance of the eyes to total health and well-being, especially of the young. The permanent exhibit is triangular, with each side describing a different aspect of vision.

Computers: Issues and alternatives

By Jeffrey Rich, special to Michigan Medicine



Decisions are simple: all you have to do is make up your mind.

But in the chaotic world of automated office management systems, the alternatives can appear overwhelming. And it's easy to succumb to the hyperbole of sales pitches directed increasingly towards physicians.

This article will provide physicians contemplating such decisions with a basic understanding of the pros and cons of using a service bureau, and with key factors to consider in signing a contract to purchase a "turnkey" computer system.

Whatever form of automated system you elect to use, three principle advantages stand to justify the investment: cost reduction, greater filing and record-keeping efficiency, and the potential benefit of gaining other clinics' experiences through standard application software. A computer system should never be purchased for the primary reason of using it as a tax shelter; if tax purposes motivate your consideration more than the three principle benefits, you may be starting off on a long journey with the wrong foot.

John Anthony, general manager of MSMS Physician Service Group (PSG), says that the positive cost benefit relationship of computers applies only to the computer's use in business tasks. Costs are not reduced he says. The computer is used as a medical information aid.

In a previous article (June '81 *Michigan Medicine*) we discussed the initial needs assessment required before you can proceed in selecting a system. Once the needs of your practice have been established, you can analyze the best method of satisfying them.

Purchasing a "turnkey" computer system is one option; this is where the vendor sells you a complete system and "turns the key" over to you. For physicians who do not wish to make the major investment of time or money this entails, there is the alternative of renting computer time with a service bureau.

Pros

Service bureaus are the most popular form of automated management systems for physicians today. Involving little or no initial capital outlay, they afford the smallest of practices the luxuries of automation. Service bureaus rent time on their computers one of two ways: 1) Installing a terminal station in your office, with a direct hook-up to their central processing unit (CPU), or 2) Setting your office up in a "batch environment."

The batch environment is so named because you submit the information you wish processed by the service bureau in "batches" of manually completed forms. In return you get regular, perhaps monthly, reports of whatever data you agreed to have them supply you with. Examples of these reports could be inventories, aged accounts, accounts receivable and payable, or any other management records you need kept.

With a terminal station you avoid the drudgery of manually filling out the forms, and instead, directly enter the data into the CPU from your office. In this system, you must train your staff in the use of the equipment, whereas, little instruction is needed in manual form preparation. Each of these alternatives avoids the major initial investment and long term contract involved with outright purchasing, and provides enough benefits to make it a viable choice over manual systems in many cases.

Sometimes using a service bureau becomes a permanent feature in managing some practices, while in others it is a stepping stone to purchasing one's own computer. With relatively little expense, a year or two of experience with a service bureau can familiarize you with the process of automation. Service bureaus' short-term contracts enable easy

continued on page 544

OVER 4,000 POLICYHOLDERS

In five years, we have grown from an idea—to a company insuring over 4,000 physicians with our MEDGARD: PROFESSIONAL LIABILITY, BUILDING/OFFICE PACKAGE, and UMBRELLA coverages. We believe there are good reasons for this. And we'd like to thank the thousands of Michigan Physicians who have supported us.

THANK YOU MICHIGAN PHYSICIANS

THE MEDGARD COMPANY

MEDGARD is not only the name of our policies . . . it represents the major part of MPMLC's philosophy of providing services to physicians. Our insureds have purchased these services to guard their homes, autos, offices, equipment, and, most important, their professional reputations in the event of a claim.

ENDORSED BY ORGANIZED MEDICINE

MPMLC is endorsed by both MSMS and MAOP&S. A distinction not easily gained, nor given to any other carrier which provides professional liability coverage for physicians.

PHYSICIAN OWNERSHIP AND CONTROL

MPMLC is your company. It is owned by physicians and run by physicians. Our Board of Directors is comprised of your colleagues who have practiced medicine in Michigan for years. Several are leaders in other professional organizations at the state and national levels.

EXCELLENT CLAIMS SERVICES

"Keep up the good work"
"Outstanding"
". . . hold MPMLC in high regard."

These are comments from physicians who responded to our Closed Claim Questionnaire. We don't tell you after a claim has been settled. We ask you for your consent first.

YOUR COMPANY THANKS YOU

So thank you Michigan physicians for working with us and believing in the concept of your company. We will continue to provide the professional services, diverse coverages, and responsive management which you have supported.

Michigan Physicians Mutual Liability Company

Watch for special announcements about our CME Category I risk management seminar at the MSMS Annual Scientific Meeting. See you in November at the Dearborn Hyatt Regency—Booth 502.

HOME OFFICE. P.O. Box 1471 · East Lansing, MI 48823 · (517) 351-1150 · (800) 292-1926 toll free
SATELLITE OFFICE: 6735 Telegraph Road · Suite 205 · Birmingham, MI 48010 · (313) 647-5550

entry or escape, as opposed to the long term, complex commitments of turnkey systems.

The growing popularity of service bureaus increases the likelihood of finding a company with experience directly applicable to your own situation.

It is important that the chosen company be familiar with the subtleties of third party payment, patient histories and internal and external reporting requirements. If there are too many errors in insurance forms, or the monthly reports come to you in incomprehensible formats, the cost efficacy of your investment will be greatly diminished. Do not hesitate to shop around for a service bureau with a strong track record in practices like your own.

No individual user bears the brunt of hardware or software expense, and with batch environments, the problems of equipment maintenance and staff training are avoided altogether. The expansion of computer use into other facets of your office functions is less complicated, since you need not bother with software modification as you would with an in-house system. Neither must you worry about "down time," or the occasional lapse in computer function rendering it inoperable until corrections are made. It is the service bureaus' responsibility to provide back-up system support.

Cons

There are certain drawbacks to service bureaus which also must be considered. Just as there is minimal capital outlay involved, a long-term user builds no equity. You are paying for a service rendered; you are not purchasing a product. With short-term contracts you are susceptible to fluctuating fees, adding variables to budget forecasts. There is the chance that the company you deal with may go out of business, forcing you to begin anew with another service bureau that uses different software programs.

When others do your data processing, you must rely on their level of efficiency. The computer industry has a high rate of employee turnover, potentially affecting the quality of their service. With this system you relinquish a good deal of control over your access to this information. A spontaneous need for a patient's financial statement, or a current office report, involves more than merely opening a file cabinet, since this information is stored in somebody else's office. If instant retrieval of information is your need, then service bureaus are not for you.

The service bureau's competence with third party payor forms has a direct effect on your collection efficiency. There is a margin of error over which you have no control. It is important that the service bureau keep abreast of developments in reporting requirements, or you may find your aged accounts file unpleasantly swollen.

A final consideration pertains to batch type environments, the least expensive path to automation. If your office does a great deal of forms processing, you may find that the work required to manually complete the service bureau forms is comparable to that of the original system, before automation. Should this prove to be the case, you may rightfully ask why you ever converted it in the first place.

At this stage, it is rare for a private physician to purchase a turnkey system, as the workload of a single practitioner's office does not often make the investment of an in-house computer cost effective. With the downward trend in prices it will become more commonplace in the near future, but at present it is most often in practices involving three or more physicians that we find computers.

Contracts

If you elect to incorporate an in-house computer system into your practice, then be sure you understand the key elements the contract should include. As with the purchase of any expensive piece of laboratory equipment, urges the AMA Department of Computer Systems, have a "lawyer or accountant review the contract, particularly concerning implications on clinic cash flow and vendor indemnity liability."

Vincent Gebes, of Management Team, Inc., Lansing, urges physicians to follow seven major points in signing a contract with a vendor for purchasing an in house computer system.

First, *all agreements must be documented*. If you obtain a verba guarantee on any facet of the system's performance, and you become disenchanted with it at some future point, the vendor may disclaim responsibility due to your misinterpreting his promises. Remember, the more experience you have with computers, the more you will expect ou of them. What you consider to be a fair memory capacity at the outset may prove dreadfully inadequate to you five years later.

Before anything is signed, obtain an *itemized list of hardware and software system components*. Be absolutely certain that you know precisely what you are buying additional software packages, for instance, can cost 60 percent over the hardware pricetag.

The *obligations and responsibilities of both parties should be detailed in advance*. The physicians office cannot have an inadequate electrical system to accommodate the computer. Subsequent power overloads would result in costly and irritating down time, and big repair bills. System site preparation is one of these factors to be decided in the planning stages.

Outline specific costs and starting dates for system operation. It is not unheard of for a vendor to require months to deliver the system, and then fail to have the system operating for several more months while the "bugs" are worked out. All this time you may be making payments on this new system and incurring the cost of maintaining your old one.

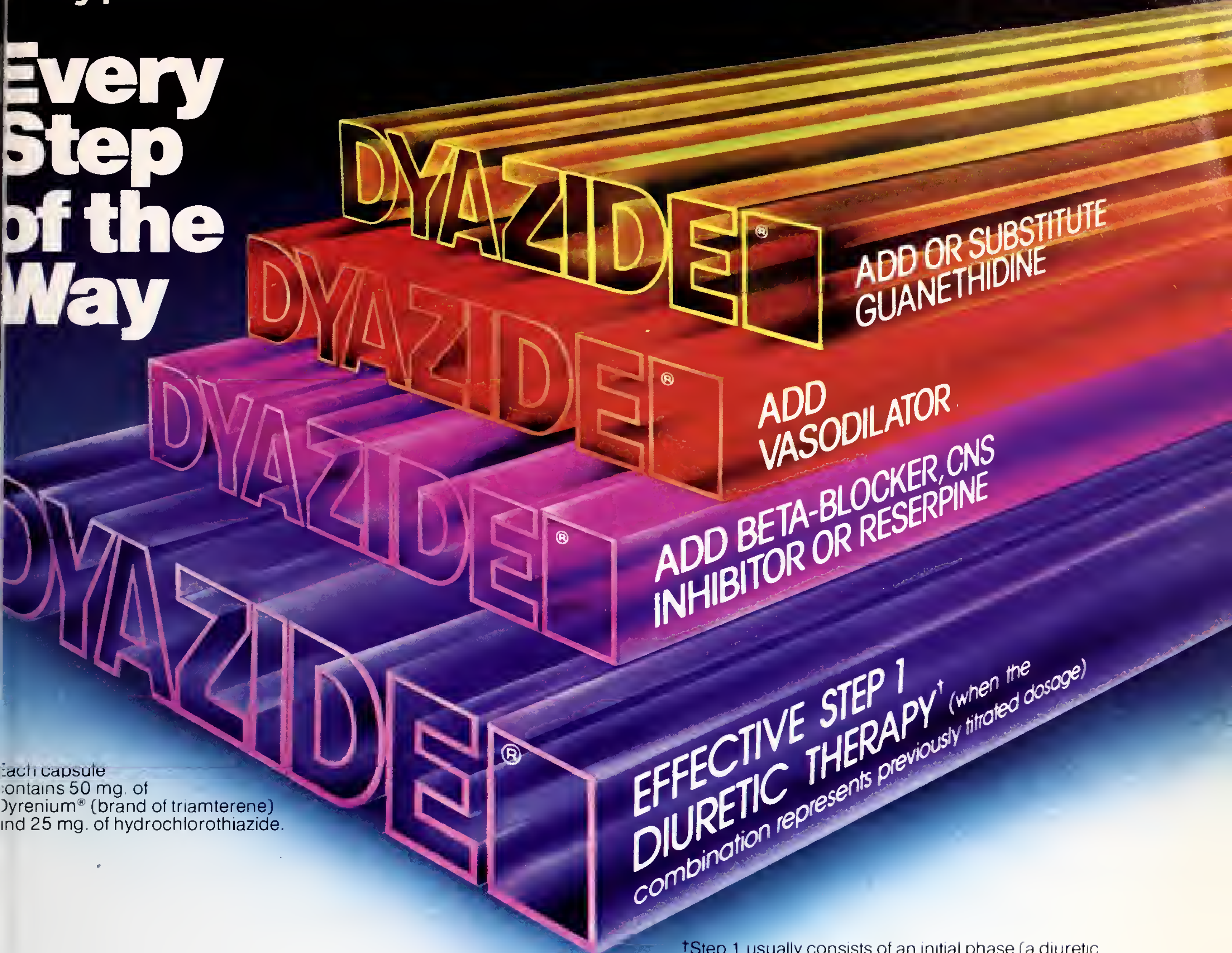
It is important that you *define the condition of acceptance* of the hardware and software, lest you find yourself straddled with bills for a system that is unsatisfactory. Do not think that once a system has been delivered you have to live with it; if it is not what was promised, leave yourself recourse for escape from the contract.

Specify the *guarantees of vendor performance*, so that you are assured of follow-through on promises of delivery, and if necessary, repairs and maintenance of the equipment.

Just as the conditions for accepting the package were defined, you should also *spell out the conditions for exit, or release from the contract*.

n Hypertension*...When You Need to Conserve K+

very
Step
# of the
Way


DYAZIDE®
ADD OR SUBSTITUTE GUANETHIDINE
DYAZIDE®
ADD VASODILATOR
DYAZIDE®
ADD BETA-BLOCKER, CNS INHIBITOR OR RESERPINE
DYAZIDE®
EFFECTIVE STEP 1 DIURETIC THERAPY† (when the combination represents previously titrated dosage)

ach capsule
ontains 50 mg. of
yrenium® (brand of triamterene)
nd 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K+ supplement or K+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K+ supplement or K+-sparing agent).

Serum K+ and BUN should be checked periodically (see Warnings).

efore prescribing, see complete prescribing information SK&F Co. literature or *PDR*. The following is a brief ummary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension Edema or hypertension requires therapy titrated to the individual If this combination represents the dosage so determined, its use may be more convenient in patient management Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant

ontraindications: Further use in anuria, progressive renal hepatic dysfunction, hyperkalemia Pre-existing elevated erum potassium Hypersensitivity to either component or ther sulfonamide-derived drugs

arnings: Do not use potassium supplements, dietary or therwise, unless hypokalemia develops or dietary intake potassium is markedly impaired. If supplementary potasum is needed, potassium tablets should not be used Hyperalemia can occur, and has been associated with cardiac regularities. It is more likely in the severely ill, with urine olume less than one liter/day, the elderly and diabetics with uspected or confirmed renal insufficiency Periodically, erum K+ levels should be determined If hyperkalemia evelops, substitute a thiazide alone, restrict K+ intake **Assoiated widened QRS complex or arrhythmia requires rompt additional therapy.** Thiazides cross the placental arrier and appear in cord blood Use in pregnancy equires weighing anticipated benefits against possible hazrds, including fetal or neonatal jaundice, thrombocytopenia, ther adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk If their use is essential, the patient should stop nursing Adequate information on use in children is not available Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency Watch for signs of impending coma in severe liver disease If spironolactone is used concomitantly, determine serum K+ frequently, both can cause K+ retention and elevated serum K+ Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides Triamterene is a weak folic acid antagonist Do periodic blood studies in cirrhotics with splenomegaly Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods Corrective measures should be instituted cautiously and serum potassium levels determined Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium Chloride deficit may occur as well as dilutional hyponatremia Serum PBI levels may decrease without signs of thyroid disturbance Calcium excretion is decreased by thiazides 'Dyazide' should be withdrawn before conducting tests for parathyroid function

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone Triamterene has been found in renal stones in association with other usual calculus components Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

SK&F CO.
a SmithKline company
Carolina, P.R 00630

No one wakes up thinking, "Today I'm going to abuse my child."

Abuse is not something we think about. It's something we do.

Last year in America, an estimated one million children suffered from abuse and neglect, and at least 2,000 of them died needless, painful deaths.

The fact is, child abuse is a major epidemic in this country.

The solution? Part of it lies in your hands. With enough volunteers, local child abuse prevention programs could be formed to aid parents and children in their own communities. With your help, most abusers could be helped. Please write for more information on child abuse and what you can do.

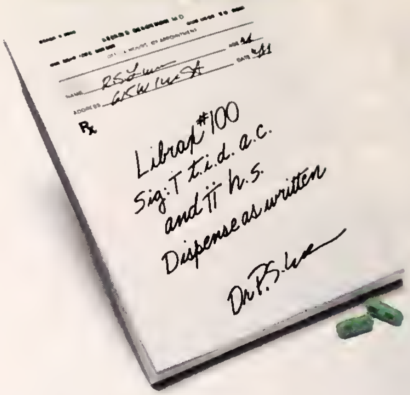
What will you do today that's more important?

Abused children are helpless.
Unless you help.

Write: National Committee for
Prevention of Child Abuse,
Box 2866, Chicago, Ill. 60690

A Public Service of This Magazine
& The Advertising Council

Specify
Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e g*, operating machinery, driving) Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

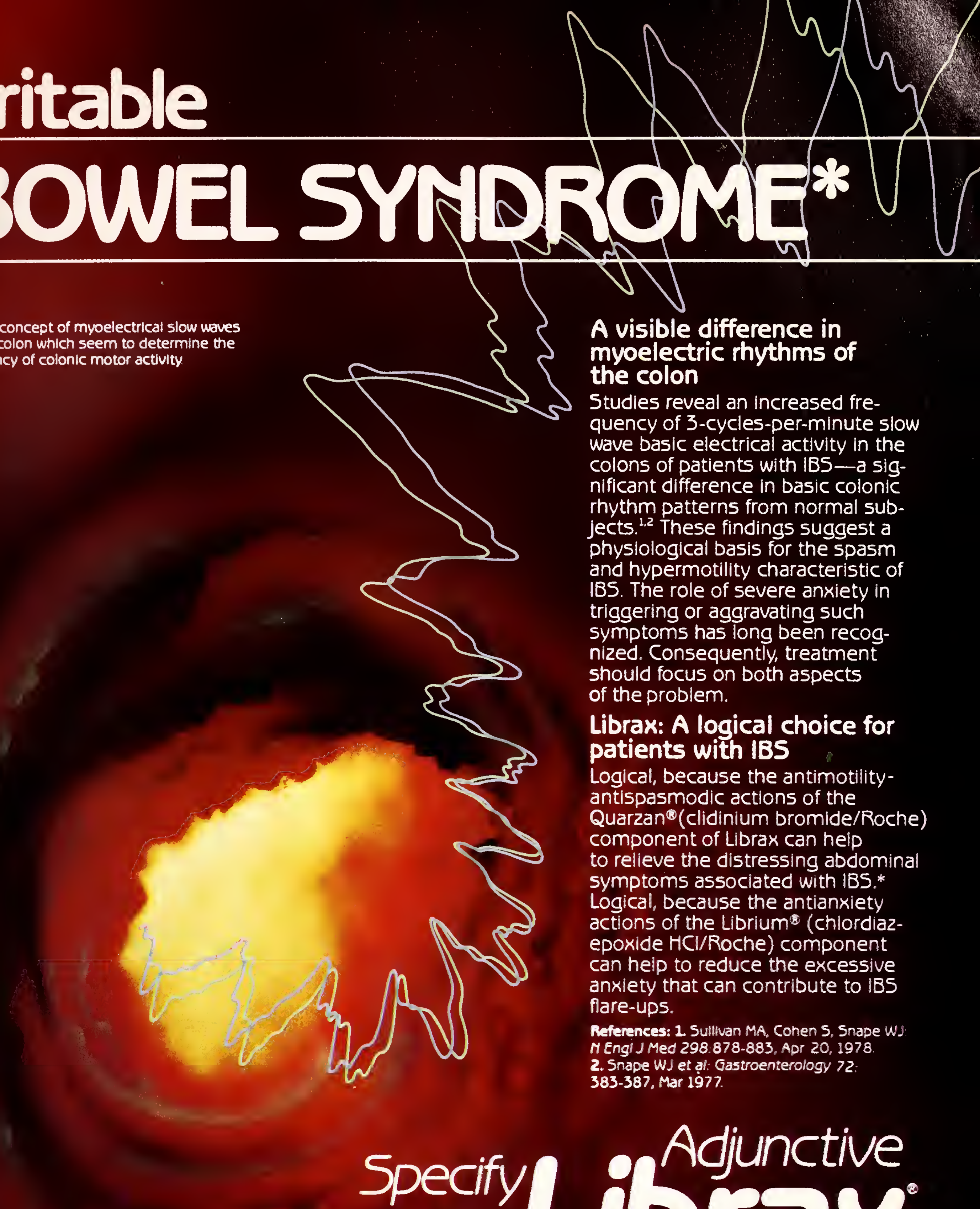
As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines Observe usual precautions in presence of impaired renal or hepatic function Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges Syncope reported in a few instances Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy Adverse effects reported with Librax typical of anticholinergic agents, *i e*, dryness of mouth, blurring of vision, urinary hesitancy, constipation Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

ROCHE®
Roche Products Inc
Manati, Puerto Rico 00701

Irritable BOWEL SYNDROME*



Artist's concept of myoelectrical slow waves of the colon which seem to determine the frequency of colonic motor activity

A visible difference in myoelectric rhythms of the colon

Studies reveal an increased frequency of 3-cycles-per-minute slow wave basic electrical activity in the colons of patients with IBS—a significant difference in basic colonic rhythm patterns from normal subjects.[1,2] These findings suggest a physiological basis for the spasm and hypermotility characteristic of IBS. The role of severe anxiety in triggering or aggravating such symptoms has long been recognized. Consequently, treatment should focus on both aspects of the problem.

Librax: A logical choice for patients with IBS

Logical, because the antimotility-antispasmodic actions of the Quarzan® (clidinium bromide/Roche) component of Librax can help to relieve the distressing abdominal symptoms associated with IBS.* Logical, because the antianxiety actions of the Librium® (chlordiazepoxide HCl/Roche) component can help to reduce the excessive anxiety that can contribute to IBS flare-ups.

References: 1. Sullivan MA, Cohen S, Snape WJ: *N Engl J Med* 298:878-883, Apr 20, 1978. 2. Snape WJ et al: *Gastroenterology* 72: 383-387, Mar 1977.

Specify Adjunctive **Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

ROCHE®

*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.

Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional mode illustrates dramatically the benefits of a successful weight loss program.

5
40
35
30
25
20
15
getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate* Dospan* CIV

(diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation." [2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate–it makes sense.
And it's responsible medicine.

Merrell Dow

*Registered Trademarks of MERRELL-NATIONAL LABORATORIES Inc.,
Cayey, Puerto Rico 00633

Referances: 1 Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride In Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed, New York Raven Press, 1978, pp. 391-404

Tenuate* CIV
(diethylpropion hydrochloride USP)
Tenuate Dospan* CIV
(diethylpropion hydrochloride USP)
controlled-release
AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma Agitated states. Patients with a history of drug abuse During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result)

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused There have been reports of subjects becoming psychologically dependent on diethylpropion The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe There are reports of patients who have increased the dosage to many times that recommended Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personalty changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia *Use in Pregnancy* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks *Use in Children* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen Tenuate may decrease the hypotensive effect of guanethidine The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage Reports suggest that Tenuate may increase convulsions in some epileptics Therefore, epileptics receiving Tenuate should be carefully monitored Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride *Central Nervous System* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses In a few epileptics an increase in convulsive episodes has been reported *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances *Allergic* Urticaria, rash, ecchymosis, erythema *Endocrine* Impotence, changes in libido, gynecomastia, menstrual upset *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia *Miscellaneous*. A variety of miscellaneous adverse reactions has been reported by physicians These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release One 75 mg tablet daily, swallowed whole, in midmorning Tenuate is not recommended for use in children under 12 years of age

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states Fatigue and depression usually follow the central stimulation Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine*) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

Product Information as of June, 1980

Licensee of Merrell*
MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

Direct Medical Inquiries to

DOW

MERRELL DOW PHARMACEUTICALS INC
Subsidiary of The Dow Chemical Company
Cincinnati, OH 45215, U S A

Merrell Dow

1-8164 (Y449C) MNQ-717

Malpractice: 25 years hasn't changed much

Does all this sound too familiar? The interesting thing is, it was written in 1946 by Louis J. Regan, MD, LLB, Los Angeles, and presented in a paper to the General Meeting of the 75th Annual Session of the California Medical Association. At the time, Doctor Regan saw an "alarming and vicious malpractice situation" in which a post-war economic recession might precipitate a marked increase in the number of malpractice claims.

There are many unsolved problems in medicine. There are many conditions the cause of which is unknown. The importance of removing or controlling a causative factor is axiomatic.

In respect to malpractice we do know the precipitating cause. Almost every malpractice claim is instigated by a physician. That may seem to be a harsh statement but it is the truth. Unethical and destructive criticism by one physician of the professional care rendered a patient by another physician is the cause of most of the unjust malpractice accusations. Such criticism acts as a sort of virus which implanted in the mind of the patient produces, after an incubation period of varying length, the inevitable result.

We know the chief cause of this plague. However, the cause is not easily controllable. It seems that to refrain from criticism is almost beyond the power of some of us. Why is it that physicians are so prone to criticize their colleagues? There appears to be no simple answer to this question. There is no denying the fact, however, nor that the effects are deplorable.

It is not suggested at all that any physician should conceal or cover up an instance of actual malpractice whether on his own part or on the part of another physician. But that is not the point we are considering. The important questions to ask ourselves now are: can any physician fairly and ethically criticize the work of or the result obtained by another physician until and unless he is in possession of all of the facts of the case? Must he not have the story of the physician as well as the patient's story?

Contributory causes

There are some contributing causes which should be mentioned in any discussion of the etiology of malpractice, particularly the following:

1. Failure of the physician to exercise tact in his contact with the patient and the patient's family.
2. Charging excessive fees.
3. The use of irritating fee collection methods.
4. Making over-optimistic prognosis, promising too much to the patient.
5. The failure to prepare the patient for reasonably to be anticipated anatomical, cosmetic or functional defect or deficiency.
6. The delegation of duties to poorly qualified assistants beyond their capacity to perform.
7. The physician absenting himself without notice to his patients, and without arranging to have a well-qualified substitute available.
8. The failure to have a consultant see a patient who is complaining of his care or progress.
9. The making of statements which can be construed as admissions of fault.
10. The physician telling the patient that he has malpractice insurance coverage.
11. The failure to warn the patient against his unwise course when he does not follow advice, or discontinues treatment before he should.
12. The undertaking to treat cases not well within the physician's experience and understanding.
13. Failure to secure consent to operation and for autopsy.
14. Failure of the physician to keep abreast of developments in his profession.
15. Utilization of procedures of an experimental character.
16. Failure to employ x-ray and clinical laboratory facilities in diagnosis and in treatment.
17. Failure to exercise ordinary care in maintaining plant and equipment in a safe condition, and
18. Abandonment of the patient.

While there are some other contributing causes of malpractice which might be noted, every physician should at least bear these eighteen in mind and should protect himself accordingly. In any consideration of malpractice, because of their paramount importance, reference should be made to medical case records. It must never be forgotten that good records afford the physician his greatest protection against any malpractice claim.

Preventing patients' injuries Nov. 17 topic

MSMS in cooperation with the Michigan Physicians Mutual Liability Company is presenting a new course during the 1981 MSMS Annual Scientific Meeting Nov. 17-18-19. The course is entitled, "A Systematic Approach to Preventing Patient Injury." It will be presented at 1:30 p.m., Tuesday, November 17, during the Annual Scientific Meeting at the Dearborn Hyatt Regency.

Instructor for the course is William R. Fifer, MD, FAACP, professor of medicine and public health, University of Minnesota. He is a widely published author, and has made many presentations on quality assurance and risk management. There also will be a reactor panel of physician specialists in emergency medicine, anesthesiology, surgery, and obstetrics and gynecology.

Physicians insured with MPMLC will be reimbursed for their registration fee following verification of attendance.

Registration is limited to 120 participants and should be made directly with MSMS. Early registration is advisable.

Does the rise in the prime rate cause a rise in your blood pressure?

International Diamond Corporation
offers fine diamonds, a safe and secure asset for the '80s.

The 1980s promise to be a time of financial insecurity, high inflation, up-and-down gold prices and stock market instability. Only investment quality diamonds offer investors a steady, nonvolatile way to store wealth and increase your investment value.

International Diamond Corporation, the leader in investment diamond services, protects your investment safely and securely with:

- Insured grade accuracy, guaranteed in writing
- 10-year history of successful liquidations (resales)
- Audited records of profits to our customers
- Up-to-date computerized market reports
- The IDC "diamond banking" service, including the exclusive IDC Passbook Account to record your diamond acquisitions

Please contact one of our District Managers in your area to learn more about "diamond banking."

Armand Dion,	Flint	313-232-4470
John Burns,	Troy	313-588-7730
Richard Foster,	Adrian	517-265-3530
Paul French,	Three Rivers	616-273-9537
Roger Jones,	Lansing	517-323-7314
Dan Junttila,	Calumet	906-337-0500
Arnie Peterson,	Calumet	906-337-0500
Bernie Sementelli,	Flint	313-232-6820
Fred Berkman,	Bay City	517-893-9243
Ray McDermett,	Traverse City	616-941-4585
Bob Stritzinger,	Grand Rapids	616-459-2863

MICHIGAN REGIONAL HEADQUARTERS
James A. Fannon, 2120 - 44th Street, S.E., Grand Rapids, MI 49508 616-455-4310

International Diamond Corporation

Do you know

**a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?**

*If so, please contact
your MSMS Committee to
Assist Impaired Physicians
through Marce Ireland at MSMS
headquarters (517) 337-1351*

Keep those AMA-ERF funds coming

By Dorothy J. Csonka, Essexville

Michigan State Medical Society Auxiliary members contributed $37,381.15 to the AMA Education and Research Foundation through a variety of fund-raising projects in 1980-1981.

Two of our country auxiliaries were honored for the effort at the AMA Auxiliary Convention. They are the Bay-Arenac-Iosco chapter for giving over $50 per capita, and the Dickinson-Iron chapter of the Upper Peninsula, for being the most innovative. We are especially proud of this latter 19-member county auxiliary which raised $531.50 at a cocktail party and jewelry sale. This was the chapter's first fund-raiser for AMA-ERF and yet it was chosen for recognition among all the county auxiliaries in the 12 North-Central States.

Our statewide AMA-ERF goals this year center around 100 percent participation of county auxiliaries and a 10 percent increase from each county. Since medical schools can be specified by the donor (except for the Student Loan Fund), I'm encouraging a "keep it at home" policy. All donations not specified otherwise will be divided equally among our three Michigan medical schools.

These unrestricted funds have been put to very good use, and I've been assured that the schools rely upon them. Last year, the University of Michigan bought $20,000 worth of equipment for their new Learning Resources Center, a special library for medical studies. Michigan State University and Wayne State University use their funds in a revolving loan fund used by students in a financial emergency.

To help us keep those funds coming in, the medical school deans of the University of Michigan and Michigan State have graciously arranged for me to receive a team-autographed football and basketball which will be used for a statewide raffle later this year. This kind of cooperation is a state chairman's dream, and humbly acknowledged.

In addition to the chance of winning such a keepsake, the Auxiliary has more mundane but useful items for the busy physician. We offer for instance, five types of remembrance cards, including one expressing gratitude for physicians' courtesy services. A variety pack of these cards in your desk can save time and temper.

If you need Christmas cards or stationery, your local auxiliary has a lovely selection, and especially lovely is the fact that 40 to 50 percent of the price paid goes to AMA-ERF.

Last, but not least, we can obtain for you a 15 minute slide presentation on AMA-ERF showing how the funds are raised and used across the country. It's brand new this fall and very well done, and would be especially suitable for a joint medical society-auxiliary meeting.

To obtain any of these materials, check with your spouse, your local AMA-ERF Chairman, or drop me a postcard at 14 Sovey Court, Essexville, 48732.

Mrs. Csonka is AMA-ERF chairman for the MSMS/A.

There's always room for improvement . . . in your business communications. So call this toll-free number

1-800-482-2900

and ask about the "Business Improvements" brochure.

Michigan Bell
Affordable Business Improvements From Michigan Bell

Nobody's perfect. And the very first step toward improving your business communications could be a toll-free call to 1-800-482-2900 right now! Just ask about the brochure "Affordable Business Improvements from Michigan Bell," which is yours at no obligation.

Improve your equipment!

This informative brochure suggests dozens of ways you can improve your business communications techniques in a wide variety of ways; for example, through up-to-date equipment such as Touch-a-matic® Telephones, Dialog™ Intercom Systems, Speakerphones, Com Key® key telephone Systems and Horizon® Communications System, the new computerized self-programmable system . . . to name just a few.

Improve your services!

There are services available that can put an end to missed business calls—services that let your calls follow you when you leave your office, and sales services that show you how to improve sales and collections, and streamline your marketing techniques.

Improve your out-of-town business!

The brochure tells you ways you can "branch out" without leaving town, through a telephone service called Remote Call Forwarding. Foreign Exchange Service gives you local access to any area of the United States. 800 Service is still another way to make it easier for customers to reach you in seconds.

Improve your data transmission system!

The Dataspeed® 40 Terminal is one of the most advanced terminals offered anywhere! And if you want a fast, economical way to talk to your computer, you'll want to know more about Teleprinter 43. And that barely scratches the surface of the Michigan Bell data developments that could readily improve your business.

To get this fact-filled brochure at no obligation call the toll-free number above, or mail the coupon.

MICHIGAN BELL BUSINESS COMMUNICATIONS CENTER
Program Headquarters
101 Union Street
Plymouth, Michigan 48170

MM

Please send, without obligation to me, your brochure "Affordable Business Improvements from Michigan Bell."

Name ____________________ Title ____________________

Company ____________________ Area Code ( ) ____ Business Phone No. ____________________

Street ____________________ City ____________________ State ________ Zip ________

Michigan Bell

"See you at Booths #302 & 304 at the

MEDICAL NEWSFRONTS

Henry Ford Hospital's Division of Bone & Mineral Metabolism has been awarded a $900,000 five-year grant from the National Institutes of Health (NIH) to study 200 women who have the bone-thinning disease osteoporosis. A parallel NIH study is being conducted at the Mayo Clinic.

The study will test the safety and effectiveness of the drug sodium fluoride in preventing further fractures in patients with the disease. Osteoporosis affects about one third of all white women over age 60 but begins in the post menopausal period.

Patients in the near-million-dollar study will be white, post menopausal women aged 45 to 75. Osteoporosis is most prevalent in white women; black women, white men and particularly black men have greater bone mass than white women at almost any given age and are, thus, affected less. Patients selected for the study will have sustained at least one fracture. (Most common are those of the wrist, hip and spine.)

Half the patients will receive sodium fluoride along with Vitamin D and calcium supplements, and half will get only the vitamin D and calcium treatment. Patients will be followed for four years and results compared.

The American Lung Association of Michigan has announced the availability of an updated guide on the classification and diagnosis of tuberculosis that should be a ready reference for every health professional involved in the care of tuberculosis patients.

The 1981 edition of *Diagnostic Standards and Classification of Tuberculosis and Other Mycobacterial Diseases* prepared by the American Thoracic Society contains a further refinement of the 1974 classification of TB for those with no current disease but history of previous episodes of tuberculosis.

Copies of the 1981 Diagnostic Standards can be requested free, as a Christmas Seal service, by calling toll free 1-800-292-5979.

A team of Wayne State University researchers have found that prostacyclin, a substance which prevents blood clot formation, appears to prevent the spread of cancer cells.

Kenneth V. Honn, PhD, reported in a recent issue of Science that prostacyclin inhibited the spread of melanoma cells in mice. Dr. Honn is Assistant Professor in the Departments of Radiation Oncology and Radiology at the WSU School of Medicine. His co-researchers are Bruce Cicone and Anne Skoff.

Scientific evidence suggests that metastasis begins when tumor cells interact with platelets, the blood cells involved in clot formation. Joined with platelets, the cancer cells may then begin to move through blood vessels to new locations in the body. Doctor Honn and other researchers believe that this attachment to blood platelets protects the tumor cells from being destroyed by the body's natural defenses.

Doctor Honn and his colleagues tested the anti-metastatic properties of prostacyclin by injecting it into mice before exposing the laboratory animals to melanoma. They found a 70 percent reduction in the number of metastatic tumors in the lungs and complete absence of metastatic tumors in the liver and spleen.

Conversely, the researchers showed that when the mice were injected with an agent that prohibited the natural formation of prostacyclin, there was a significant increase in the number of metastatic tumors.

In a related research project, Doctor Honn and his colleagues Bonnie Sloane, PhD, and Phil Cavanaugh found an excess of the enzyme, cathespin B, in mouse cancer cells. Their research suggests that this enzyme may cause cancer cells to detach from the primary tumor and begin their travel to other parts of the body. Doctor Honn suggests that "elevated levels of cathespin B may be a good marker for tumor cells with metastatic potential."

1.5 million Vietnam veterans may need psychiatric help for war related stress, according to an article in the Aug. 14 *Journal of the American Medical Association.*

Even though symptoms are well-defined, the unusual characteristics of the war, coupled with negative public opinion, have created a hesitancy in vets to talk about their problems. This hesitancy has caused many to turn elsewhere for help, often with disastrous results, says John Ingram Walker, MD, Psychiatrist at Duke University Medical Center and the Veterans Administration Medical Center, Durham, N.C.

A total of 2,769,000 men served in Vietnam. The number of these veterans currently hospitalized for alcohol-related problems more than doubled from 1970 to 1977, moving from 13 per cent to 31 per cent of all treated. Vietnam vets account for 39 per cent of the 10,000 inpatients and

continued on page 557

South Macomb Internists, P.C.
is pleased to announce
the establishment of
South Macomb Thyroidology
under the direction of

DAVID L. THOMSON, M.D.
(Diplomate ABIM-certified
Endocrinology and Metabolism)
Available Services Will Include:

PHYSICIAN ASSESSMENT
RADIONUCLIDE IMAGING
RADIOACTIVE IODINE THERAPY
THYROID FUNCTION TESTING

11012 E. 13 Mile Road
Warren, Michigan 48093
Telephone (313) 751-7171

You've got enough to know without having to know another business too.

Collecting over-due bills takes lots of expertise. You have to know the psychology of helping people to pay. And, you must know, and comply with, the myriad of consumer protection laws.

I.C. System has the expertise. That's why we are able to collect over $4 million a month, nationwide, for satisfied business and professional clients.

Fill out this card and mail it to find out how

The System Works IC

Tell me more about the I.C. System program.

I. C. COLLECTION SERVICE
Michigan State Medical Society
Physician Service Group, Inc.
1305 Abbott Road
East Lansing, Michigan 48823

Name (Practice) ____________________

Address ____________________

City ____________ State ______ Zip ________

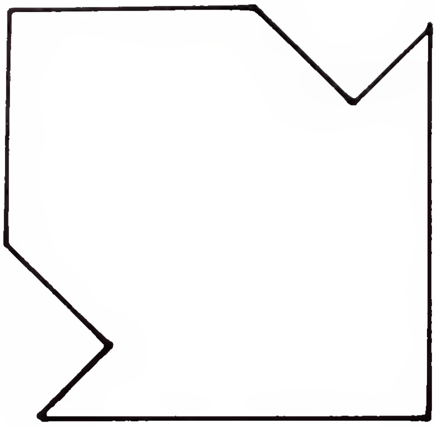
Signed ____________________

Title ____________________

Form No. 3342

I.C. SYSTEM, INC., 3499 North Lexington Avenue, P.O. Box 43639, St. Paul, MN 55164

NEW MEMBERS



Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Paul A. Bruer, MD IM
7527 S. Riverside
Marine City, 48039

Cesar P. Casten, Jr., MD FP/PTH
216 N. Main, Box 209
Standish, 48658

Eugene J. Chapp, MD PD
6777 W. Maple Road
West Bloomfield, 48033

Richard M. Delnay, MD U/AN
1005 W. Green St.
Hastings, 49058

William D. Ensminger, MD ON/IM
Univ. Hosp. Rm. W4545 Box 055
Ann Arbor, 48109

M. Jeannette Espy, MD OBG
1300 Lafayette, E. #606
Detroit, 48207

Irving H. Fox, MD IM
Univ. Hosp. Rm. W4642 Box 055
Ann Arbor, 48109

Sneh Gupta, MD R
6500 John C. Lodge
Detroit, 48202

Julian T. Hoff, MD NS
U-M Medical Center C5083
Ann Arbor, 48109

Ming H. Huang, MD OBG
1300 Jasberg St. Box 89
Hancock, 49930

B. G. Kamlapurker, MD GS
Pigeon Clinic
Pigeon, 48755

Gurudarshan S. Khalsa, MD FP
27330 Southfield Road
Lathrup Village, 48076

Vithal B. Kinhal, MD IM/CD
20927 Kelly Road
East Detroit, 48021

George H. Mayol, MD FP/PTH
7293 Michigan Avenue
Pigeon, 48755

Jeffrey A. Meer, MD IM
23077 Greenfield Road, #205
Southfield, 48075

Daniel M. Mitchell, MD FP
3232 Shroyer Road
Kettering, OH 45429

Renato A. Oteyza, MD GS
146 S. Johnson Street
Pontiac, 48053

Vasantha Rajagopal, MD GP
5482 Overhill Drive
Saginaw, 48603

Surendra H. Raythatha, MD FP
7293 Michigan Avenue
Pigeon, 48755

Michael J. Redmond, MD D
2120 Buckingham
Birmingham, 48008

Ralph G. Ryan, MD CD/IM
1560 E. Sherman Blvd.
Muskegon, 49444

Issac Schaver, MD IM/PUD
17000 W. Eight Mile Rd.
Southfield, 48075

Marilee G. Shebuski, MD PD
1121 Dow Road
Alpena, 49707

Michael J. Slavin, MD FP
835 N. Midland Road
Saginaw, 48603

Allan M. Smiley, MD IM/RHU
13154 Borgman
Huntington Woods, 48070

Frank R,. Sprague, MD IM
1560 E. Sherman Blvd. #205
Muskegon, 49444

Richard A. Stone, MD D
198 S. Gratiot
Mt. Clemens, 48043

Joseph J. Weiss, MD IM/RHU
25738 Ivanhoe
Huntington Woods, 48070

James L. Wierman, MD IM
400 W. Division Street
Dowagiac, 49047

Albert S. Yee, MD EM
Henry Ford Hospital EM
Detroit, 48202

Jack A. Young, MD AN
38 Fordcroft
Grosse Pointe Shores, 48236

Ratnakumari Zampani, MD IM
115 Gale Blvd. #303
Melvindale, 48122

55 per cent of the 13,000 outpatients being treated for drug abuse in U.S. VA hospitals.

Approximately 29,000 Vietnam vets are currently in state or federal prisons, 37,500 are out on parole, 250,000 are under probationary supervision and 87,000 are awaiting trial. The suicide rate for Vietnam vets under the age of 34 is 23 per cent higher than that of nonveterans in the same age group, Dr. Walker says.

The unusual nature of the Vietnam war, the longest in American history, is partially to blame for the vet's inability to cope with his problem. Unlike soldiers of other wars, individuals, rather than units, were moved and rotated throughout the war, causing feelings of isolation in the soldier. The lack of home support, the absence of well-defined front battle lines and almost consistent inability to distinguish between enemy combat troops and civilians produced feelings of cynicism and mistrust, Doctor Walker declares.

Children under seven years of age grow at a faster rate than older children after kidney transplants — making them good, and in some ways better, candidates for the surgery.

This is according to a study published in the August issue of *Pediatrics*. The journal is the official publication of the American Academy of Pediatrics.

In the study, a team of physicians at Children's Hospital Medical Center in Boston studied the rate of growth of children who had received kidney transplants over an eight-year period.

Type and severity of previous illness were not found to be related to the growth rate differences between age groups, which were significant. Most of the patients who were 12 or older when they had their transplants either didn't change their rates of growth or grew less well than they had before the operation. Similar results were found in the group of patients aged between seven and 12 years at the time of transplant.

In contrast, eight of the 11 children who were between three and seven years of age at the time of transplant grew faster than normal after their operation. In seven cases, the children grew so fast — up to twice the normal rate — they were able to "catch-up" with children their own age. In most of the cases in which faster growth didn't occur, the children had rejected their new kidneys.

Women who want and need abortions will have them, it seems, no matter who pays for them.

In the two years that the Hyde Amendment was in effect, there was no significant decline in the number of abortions performed in the U.S., says an article in the Sept. 4 *Journal of the American Medical Association*.

While the amendment succeeded in almost eliminating federal funding for abortion, 94 percent of all women eligible for Medicaid funding before the amendment received legal abortions, 65 percent with state funds and 29 percent with other funds. Only five percent carried their pregnancies to term. One percent sought illegal abortions, said the report.

The NME "establish your practice" benefits package:

- *Over 60 well equipped acute care hospitals.
- *Selected financial assistance.
- *Management consulting.
- *An array of professional service skills and talents to assist you.
- *Locations from coast to coast.

If you're a Primary Care Physician, call for yours today.

For further information, contact:
Raymond C. Pruitt, Director Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.
Call Toll-Free 800-421-7470
or collect (213) 479-5526.

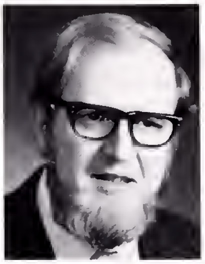
NATIONAL MEDICAL ENTERPRISES, INC. nme

"The Total Health Care Company."
An Equal Opportunity Employer M/F

NEWS

By Sheri W. Greenhoe
MSMS staff

Frame


Crow

Swisher

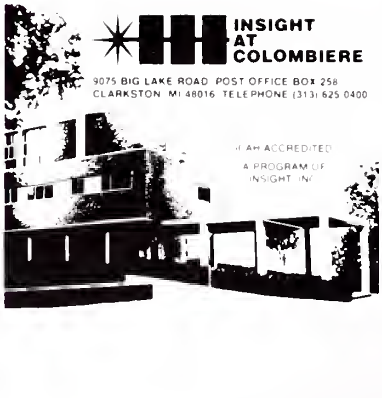
Vitu

Michigan Family Physician of the Year is **Robert L. Vitu, MD,** of Saginaw. Doctor Vitu is a 23-year member of the Michigan Academy of Family Physicians, the organization that awarded him the honor. **Harold E. Crow, MD,** of Lansing is new president-elect of MAFP. . . . More than 100 guests recently celebrated **Doctor Morris I. Goldin's** 32nd anniversary as medical director at Glen Eden Hospital, a Warren psychiatric facility. . . . **Ashok Sonnad, MD** is new Montcalm County Medical Examiner, succeeding **Carl Hansen, MD,** who resigned for health reasons. . . . **Anton Venier, MD,** and **Donald Finlayson, MD,** have retired from general practice careers in Sault St. Marie that provided a total of 68 years of service to the area. . . . Saginaw Steering Gear Division's new medical director is **Myron G. Zeis, MD,** of Northville. . . . **William DuBois, MD,** has been named the recipient of the Harry A. Towsley Award for outstanding performance as a family practice resident at Midland Hospital Center. . . . **Muthiyaliah Babu, MD,** Flint nephrologist, is "Teacher of the Year" of Hurley Medical Center's graduate medical education program. . . . Harper-Grace Hospitals' chief of surgery, **Alexander J. Walt, MD,** was honored as the visiting professor at Johns Hopkins Hospital in Baltimore recently. . . . Special Presidential Citation for "outstanding governor activity" has been awarded to **Boy Frame, MD,** of Henry Ford Hospital by the American College of Physicians. . . . Marquette physicians **William J. Addison, MD,** and **J. Marck Himes, MD,** were selected by a vote of the family practice residents of the Upper Peninsula Medical Education Program as "Instructors of the Year." . . . **Scott N. Swisher, MD,** professor of medicine and associate dean for research at Michigan State University's College of Human Medicine, has been appointed chairman of the American Institute of Biological Sciences Medical Advisory Panel to the National Aeronautics and Space Administration (NASA). . . . **A. B. Swanson, MD,** Grand Rapids, has been made honorary member of the Japanese Hand Society and a member of the European Rheumatoid Arthritis Surgical Society. . . . Egyptian mummy specialists, **Aidan Cockburn, MD,** and his wife **Eve Cockburn, MA,** Oxon., of Detroit will be honored in September by the American Medical Writers Association. The Cockburns are editors of a book that studies the evolution of disease in man. . . . **Robert P. Kelch, MD,** is new medical chief at the University of Michigan C.S. Mott Children's Hospital. . . . Second year medical student **Jayne A. Thorson,** of the University of Michigan Medical Scientist Training Program, has been selected as the program's first Margaret E. Reynolds fellow. . . . **Herbert Sloan, MD,** professor of surgery at The University of Michigan Medical School and head of the section of thoracic surgery at University Hospital, has received the Society of Thoracic Surgery's distinguished service award, the highest award bestowed by the society. . . . New Michigan Orthopaedic Society president is **Russell Cashen, MD,** Kalamazoo, and president-elect is **John Wagner, MD** of Grosse Pointe Woods. . . . **William B. Weil, Jr., MD,** of East Lansing has been appointed chairman of the American Academy of Pediatrics' Committee on Indian Health. Other Michigan pediatricians named to the Academy's national committees are: **Regine Aronow, MD,** Detroit, Committee on Accident and Poison Prevention; **Anne-Marie Ice, MD,** Detroit, Committee on Adolescence; **Ronald Poland, MD,** Detroit, Committee on Fetus and Newborn; **Robert M. Heavenrich, MD,** Saginaw, Committee on Genetics and Environmental Hazards; and **Sanford Cohen, MD,** Detroit, Committee on Scientific Program.

Fact:
Alcoholism affects some ten million families.

The important fact to remember is that alcoholism when properly treated can be arrested Our primary goal at Insight is to help people understand and deal effectively with their alcoholism — through intensive short-term therapy in a residential setting and a planned aftercare program involving families employers A A and other significant support groups

For more information call or write



INSIGHT AT COLOMBIERE
9075 BIG LAKE ROAD POST OFFICE BOX 258
CLARKSTON MI 48016 TELEPHONE (313) 625 0400

JCAH ACCREDITED
A PROGRAM OF INSIGHT INC

YOUR
INCOME
Employees' Salaries
OFFICE RENT
Utilities

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc. Check these features of the Professional Overhead Expense plan sponsored by the MSMS.

- ☑ **Up to $3,000 monthly benefit**
- ☑ **Waiver of Premium**
- ☑ **Survivors' Benefits**
- ☑ **Professional liability premiums are a covered expense**
- ☑ **Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more**

"we're here to help"

Stratton–Cheeseman & Associates, Inc.

1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823
Call Toll Free: **800-292-1966**

***1979. The National Underwriter Company**

What was unthinkable years ago acceptable, even a right, today

By A. B. White, MD, Marquette

Recently the *Journal of the American Medical Association* (JAMA 4/10/81) carried an article calling attention to a malady known as cultural narcissism. This "me-first" philosophy, while not at all new, particularly applies to and has ominous portents for affluent societies such as our own. What is of even more significance is that the author is a physician who writes from the perspective of its incursion into medical practice. He cites two examples:

1) Two investigators carried out a survey of practicing physicians, fourth year and first year medical students. A small minority of physicians admitted to having had sexual relations with their patients and saw nothing wrong with it. A larger minority of fourth year students and an even larger percentage of first year students, in prospect, saw nothing wrong about such relationships in their future practices. The investigators then concluded that these trendy developments might well require change of existing ethical codes to allow for such behavior as being entirely within societal norms.

2) It is well known that incest is much more commonly practiced than has been heretofore thought. A recent study claimed that in families where incest was practiced, a surprisingly small percentage showed any serious psychological damage. The author skeptically postulates that some future study may well show, then, that incestuous relationships are fun and will actually lead to better sexual relationships in later life.

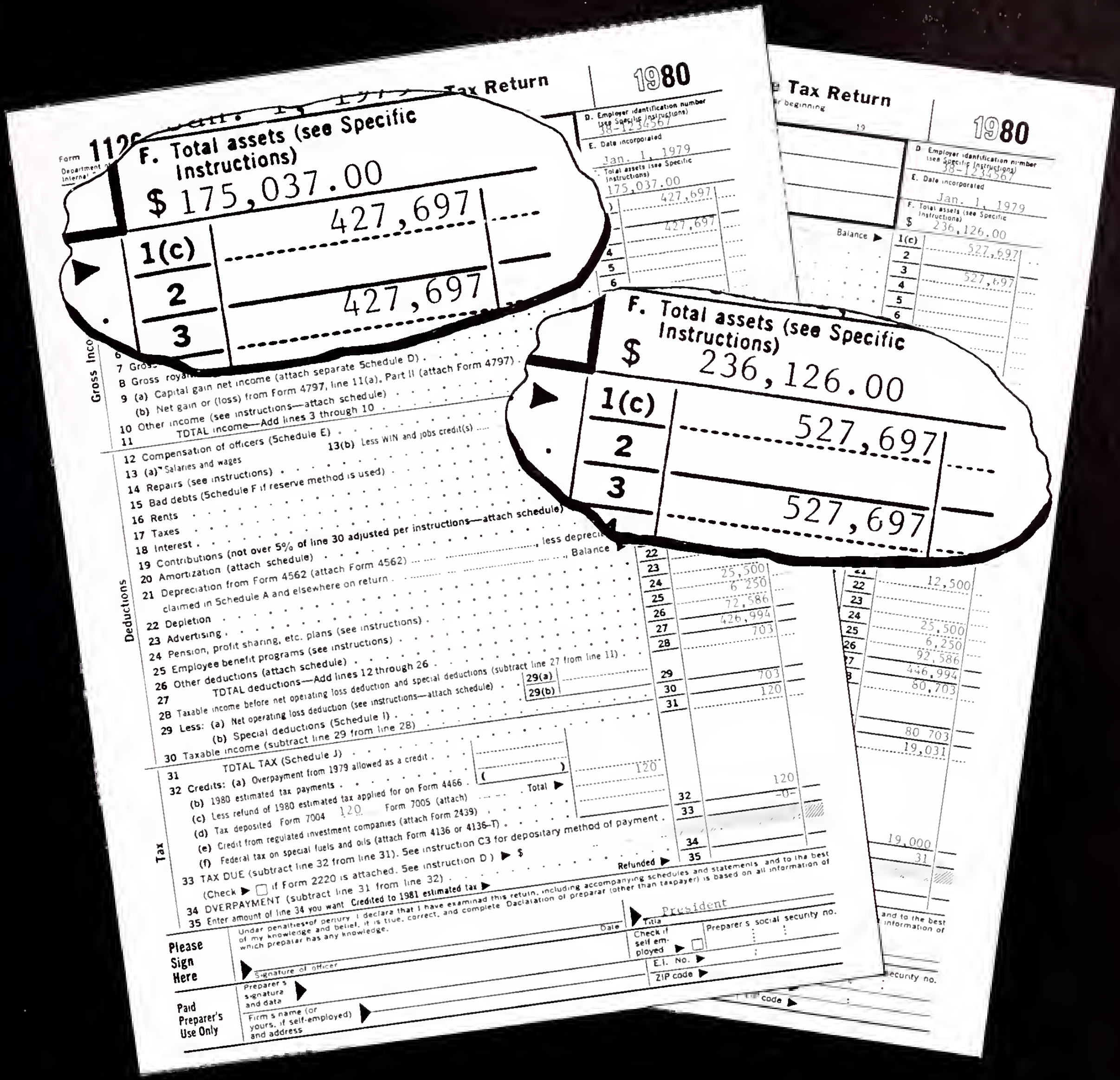
One simply must ask what this all means and where it will end. First of all, it is clear that what was unthinkable even a decade ago is now thinkable. Further, what is thinkable soon becomes acceptable and finally becomes a freedom, a right. Practice or norms become standardized, not by standards, but by polls, surveys, studies, or whatever feels comfortable. Freedom finally becomes no longer the exercise of a discerning, disciplined free will, but an actual enslavement. And there can be no enslavement quite so addicting and eventually sated as sexual slavery. Having sex without standards is to take something exquisitely beautiful and narcissistically convert it into something not only ugly, but totally destructive.

Narcissism, in my view, is a root cause of the abortion mentality so widely accepted by so many, and I suppose, therefore, the new norm. This throw away value system makes it quite ludicrous even to suggest a return to any standard of morality, let alone the Judeo-Christian ethic. And yet, it is precisely such an ethic for which, like a voice in the wilderness, I must cry out again and again.

But it is finally at this point that I would like to return to the original article in the JAMA. Cheers to this prestigious medical periodical with whose members (and I'm one of them) I've been at odds so much of the time. At least this once they have published something so very controversial and, at the same time, so valuable. The author can never go much farther in his conclusions than "perhaps," "just might," "could possibly;" but oh, how he lays out the scenario of a morally wounded and bleeding society. Perhaps, just perhaps, there will be other voices with equal authority and intelligence and, additionally, a sense of the high and holy, who will be able to point us onward, or backward, to the standards for which we all long and for lack of which our children will all surely suffer.

Doctor White is affiliated with the University Health Center at Northern Michigan University, Marquette.

Before / After


1980
Tax Return
F. Total assets (see Specific Instructions)
$ 175,037.00
1(c) 427,697
2
3 427,697
F. Total assets (see Specific Instructions)
$ 236,126.00
1(c) 527,697
2
3 527,697

You can increase your office income without increasing your overhead and payroll

Let Gamma Analysis and Distributing Co. set up and operate your own blood testing laboratory in your office.

You pay nothing for the equipment or personnel.

You are charged only for each test that is done. That's it. There are no hidden extras.

There are– • no leases for you to sign • no long term contracts • no equipment to purchase • no staff to hire • no cash outlay.

We provide the technicians, equipment and chemicals. . . you provide the space (the equivalent of a table top will do–about 3'x4') and supervision.

Top Technicians Perform Top Tests and Cut Your Staffing Needs –Gamma technologists are highly trained specialists skilled in performing such blood tests as T_3 Uptake, T_4 (RIA), TBG, TSH, T_3 RIA, Digoxin, Iron and Iron Binding Capacities, and many others –right in your office.

We Bring the Chemicals so You Don't Have to Store Reagents.

In by Nine, Out by Noon–every test that Gamma performs in your office can be completed in less than three hours.

Gamma keeps precise records of all blood tests, including all raw data and all necessary Nuclear Regulatory Commission Registration Forms.

Your Supervision is Required. . . and with Good Reason– Although Gamma provides the expertise, equipment and materials to do blood tests in your office, state law says that you can bill medical insurers only for those tests performed in your facility and under your supervision.

Call or write today for complete information.

G

**GAMMA ANALYSIS
AND DISTRIBUTING CO.**

**25050 Ford Road, Dearborn Heights, MI 48127
(313) 561-2930**

Gamma Analysis & Distributing Co. is a fully licensed Michigan corporation operating under the auspices of the Nuclear Regulatory Commission.

Amway founder tells physicians to stop apologizing

By Willah Weddon, special to Michigan Medicine

Richard DeVos, founder and president of the billion dollar Amway Corporation in Ada, didn't get where he is today by softpeddling the company's products and progress. He can't understand why physicians downplay their roles today.

"You sit around and apologize for your own achievements," he charges. "You ought to stop it. You should be shouting from the housetops about your accomplishments. You deliver the finest medical care this world has ever seen."

"Rich" DeVos, a Grand Rapids native who might be dubbed colorful if he didn't dress so conservatively, has inspired Amway employees for years with his dynamic speeches.

Inspired auxilians

He had the same effect on MSMS Auxiliary members at their 1981 annual convention in the furniture city. They gave him a standing ovation at the conclusion of his address.

His success as a speaker is due partly to expert presentation, but primarily because he appears to speak with utter conviction. And, when it comes to the medical profession, DeVos acts dedicated.

"People talk about the high cost of medicine today," he points out. "But I tell them that when I go for medical care, I'm not looking for any bargains. I don't think they are, either.

"As far as I'm concerned, when it comes to what the doctor earns, it's a bargain compared to the price he paid to get his education."

The hard-driving, tough-minded businessman recommends people looking for "cheap" medical care go someplace else . . . such as Russia. "The socialist system there provides cheap care, except for two problems," he says.

"The longevity of people in Russia is going down, not up, and the number of babies dying at birth is increasing.

"So, with all the talk about 'free," socialized, medicine, what you have is a decline in the quality of medicine. They are going in the wrong direction, compared to all of us in the free world where we continue to work toward greatness," he emphasizes.

Physicians (and their spouses) should stop apologizing for medical costs and start talking about the quality of medicine they deliver, in DeVos' opinion. "The world stands in line to enter this country for medical care."

This brings 55-year-old DeVos to voice another strong conviction: Americans need not be ashamed because they've done so well. "We can be disappointed the rest of the world has not done better, but other countries will not do better by our country doing less well.

"We must continue to stand tall and move on down the road as leaders because that is what gives hope to other people in the world," he stresses.

His background

Raised during depression years when it meant working for a nickle or not having one, DeVos teamed up with his high school buddy, Jay Van Andel, for a lifetime filled with adventure and business success. After both served in the US Air Force during World War II, the friends began a flying school and air-charter service near Grand Rapids. Two years later they sold out at a profit, bought a schooner and set out on a year-long cruise. That venture ended abruptly when the ship sank off the coast of Cuba.

Five months later, after completing the tour sans ship, they returned to their hometown and, in September 1949, formed the Ja-Ri Corporation which distributed products on a direct-sales basis.

Ten years later the partnership was still working so well the two men founded Amway Corporation in the basement office of the Van Andel home. With their belief in free enterprise and long hours of hard work by both men and their wives, the company became phenomenally successful.

The Amway Corporation produces more than 300 products in the home plant at Ada, sells these plus more than 2,000 other brand-name items to the tune of $1.1 billion retail sales in 1980. And it is privately held by the two founding families.

Today they have more than 750,000 independent distributorships throughout the world. The company is the largest exporter in Michigan. In 1978 the corporation purchased the Mutual Broadcasting System, the world's largest radio network, making the conservative influence in political campaigns no minor consideration.

Of special interest to MSMS members and Auxiliary members is the company's acquisition of the Pantlind Hotel, three years ago, where MSMS annual meetings were often held until facilities could no longer accommodate them.

A multi-million dollar renovation of the old landmark hotel in downtown Grand Rapids into the Amway Grand Plaza Hotel is now underway. A new, 28-story hotel will be built to the west of the present building and will be linked by a lobby and meeting room facility which is presently nearing completion. Walkways will connect the hotel to the new Grand Center, a Performing Arts and Convention Complex.

Administrative office and main laboratory

AMRC the full service laboratory

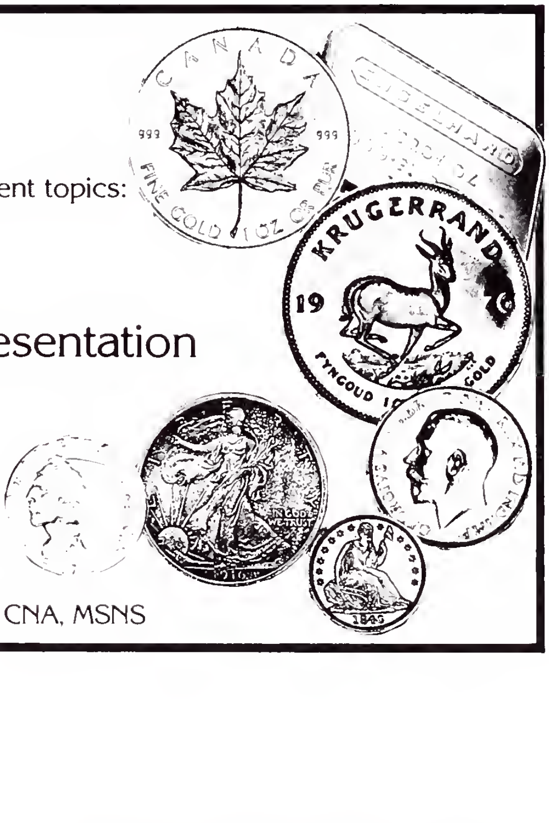
- Complete range of individual tests and diagnostic profiles
- Medical consultation services
- Comprehensive quality control program
- Fully accredited
- Complete billing service

Advance Medical &
Research Center, Inc.

1270 Doris Rd • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963



ANNOUNCING THE C.L.I.C.

SPEAKERS BUREAU

Now scheduling PRESENTATIONS on the following investment topics:

- GOLD & SILVER BULLION
- RARE COINS

To schedule a highly enlightening presentation for your next business meeting, contact:

CARLTON LUSH INVESTMENT CORPORATION
Bingham Center • Suite 1646
30700 Telegraph Road • Birmingham, Michigan 48010
(313) 646-8846

Life Members: ANA, CNA, MSNS

The decline of the independent physician continues

By Harry Schwartz
New York

Mr. Schwartz is a writer-in-residence at the College of Physicians and Surgeons, Columbia University.

Michigan Medicine reprints the following article, with permission, at the request of MSMS President James D. Fryfogle, MD.

The physician as a small businessman and independent entrepreneur, I wrote some years ago, will share the fate of the dodo and the dinosaur. The inexorable trend, I argued, was for the collectivization of doctors, their conversion in the main into hired salaried workers who would join unions and go on strike just like almost everybody else. Writing in 1971, I compared the solo physician of that time with the Soviet kulak of 1928, and predicted the former would share the latter's fate, but through economic pressure rather than the violence Stalin used to collectivize the kulaks.

Since I deplored the trend, I take no pleasure in reporting that the passage of a decade has made my forecast seem much more likely than it may have seemed originally. I return to the subject now in the hope that it is still not too late, and that if society can be made aware of what's happening the trend can be at least slowed.

The evidence is obvious. Hospitals in all parts of the country are increasingly hiring physicians in an effort to make themselves less dependent on the autonomous doctor who is free to treat his patient in any one of several hospitals. Medical schools are hiring doctors for what are euphemistically called "faculty practice plans" but which are simply factories of medical care manned by hired hands whose fees go to the school. Kaiser and other similar closed panel "health maintenance organizations" are expanding across the country. And while many Kaiser physicians are technically "partners," their everyday work reality is usually more like that of an employe.

The American Medical Association is positioning itself to try to take care of the changing needs of its changing constituency, and has now declared that "representation" of physicians is its primary task. It is hard to see that as anything but the beginning of a self-transformation toward union status. Some of the data behind this AMA internal change were recently published by that organization. It reported that just between 1969 and 1980, the number of doctors practicing in groups more than doubled, going from 40,093 to 88,290.

I've been speaking recently in New York City and Boston both to hired doctors working for hospitals and to some of the hospital officials responsible for hiring physicians. They tell complementary tales. The employers speak happily of their ability to hire top-notch board-certified internists for salaries of $40,000 or so, hardly poverty wages but only half the estimated average net income of an American physician last year. A few years ago such salaries attracted mainly foreign doctors: Indians, Koreans and Filipinos. Now those salaries are grabbed by young American men and women whose undergraduate and medical schools were both Ivy League.

The physician-workers give a variety of reasons for their willingness to become hired hands. They like the idea of a regular work day with guaranteed time off, guaranteed vacation time and the like. But many speak of the heavy load of debt they carry as the heritage of their medical training, of the high cost of opening an office of their own and paying lofty malpractice insurance bills even before they've seen their first patient. They also acknowledge they've gotten word from their friends who are a few years older that it is very difficult to make it in any really desirable area, such as the East Side of Manhattan, New York's Westchester County,

Reprinted with permission of The Wall Street Journal ©1981 Dow Jones & Company, Inc. All rights reserved.

Prepare For:

- **TOEFL**
- **MSKP**
- **NATIONAL MEDICAL BDS**
- **VQE**
- **ECFMG**
- **FLEX**
- **DENTAL BDS**
- **PODIATRY BDS**
- **NURSING BDS**

- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.
- Over 40 years of experience and success in the field of test preparation.

Stanley H. KAPLAN EDUCATIONAL CENTER

For Information Please Write or Call:

Crossroads Office Centre
16250 Northland Drive
Southfield, MI 48075
(313) 569-5320

Centers In More Than 80 Major US Cities, Puerto Rico, Toronto, Canada & Zurich, Switzerland.

r comparable places in other metropolitan areas.

There is also a feeling of despair among many older as well as younger practitioners about the fuure of entrepreneurial medicine. They see the federal government — regardless of party — as the enemy of raditional fee-for-service practice. They cite the rich government subsidies and special privileges for HMOs, and the incessant propaganda for cost containment. "All the government cares about is cutting costs. Quality of care, a personal relationship, these don't mean a thing to the bureaucrats," one doctor said to me, voicing a common complaint.

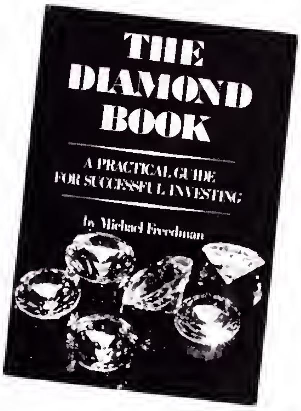
And to the extent that physicians are aware of it, there is growing worry about the Carter and Reagan pushes for price competition in medicine. The Federal Trade Commission may not believe it, but most people with an M.D. believed until recently — and many still believe — that a doctor who advertised was unethical and immoral. Also doctors notice bitterly that medical associations are being prosecuted by the FTC for doing exactly what unions do with impunity. Why should it be illegal for the Michigan State Medical Association to exert pressure on Michigan Blue Shield for higher fees for its members when nurses and newspaper reporters can go on strike for higher wages without a single objection from the FTC, the Justice Department or anybody else in Washington?

It all sounds dreadfully old fashioned when a doctor articulates the world he believes in and which he now sees crashing in ruins. It was a world in which the doctor put his patients' interests above all. It was a world in which a doctor sought patients by establishing a reputation for giving high quality, personal and humane medical care. And it was a world in which both doctors and patients willingly let fees be decided on a Robin Hood basis.

Now most fees are paid at least in part by the government or some insurance company. Now the pressure is to think of cost as well as or even before patient welfare. Now the media proclaim that only a fool believes his doctor's recommendation and eschews a second opinion. Is it any wonder some older doctors react by deciding to grab as much as they can while they can and that younger doctors decide it's too much trouble, and not worth it, to be a businessman and keep books? Unions, the latter suspect, will be better defenders of their interests than a castrated AMA could ever be.

But as the change proceeds, our society increasingly loses a large group of able and active people who have historically been among the staunchest supporters of free enterprise, economic liberty and all the institutions we lump together as capitalism. This is a period of intense and understandable governmental and corporate concentration on cutting medical costs. But even that can hardly justify a myopia which fails to realize that doctors are being converted from strong defenders of our economic order to a group that will be indifferent about whether it takes orders from private or government bosses. And some doctors, no doubt, will become active advocates of socialism. It is worth remembering that among their historic predecessors were Che Guevara M.D. and Salvador Allende M.D.

FREE! To physicians who want to learn about diamond investing — safely and with confidence.



To find out more about diamonds, which have appreciated faster than stocks, gold or silver, send in the coupon. After we meet, I will give you a free copy of this diamond reference book published by Dow Jones-Irwin. It retails for $14.95, but it's yours free in return for your time and interest in meeting with me. **CALL (313) 569-2039**

ROBERT MONDOR, NATIONAL CONSULTANT
The Diamond Trading Group
24001 Southfield Rd., Southfield, MI 48075

Tape or glue this Post-Paid Label to any envelope and mail your completed coupon to us. We pay the postage!

No postage necessary if mailed in the United States

BUSINESS REPLY LABEL
First Class Permit No. 315 Southfield, MI

POSTAGE WILL BE PAID BY ADDRESSEE

Robert Mondor, National Consultant
The Diamond Trading Group
24001 Southfield Rd.
Southfield, MI 48075

☐ Yes. I'd like to know more about your new diamond investment program. Please call me for an appointment and reserve my free copy of "The Diamond Book".
I understand there is no obligation.

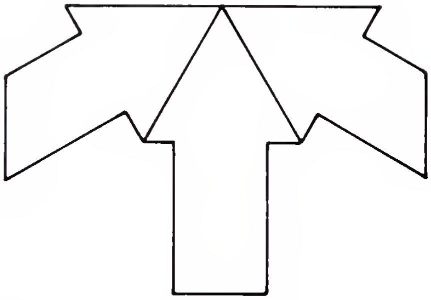
Name (please print)

Address

City State Zip

Home Phone No. Business Phone No.

MEETINGS



MSMS, MSMS/A, AMA and medical assistants

Oct. 29-30 — AMA Second Annual Health Reporting/Radio-TV Conference, Fort Worth, Texas — Hyatt Regency. Contact AMA, Office of Public Relations, 535 N. Dearborn, Chicago 60610, 312/751-6614.

Oct. 30-31 — Fifth National AMA Conference on Medical Care and Health Services in Correctional Institutions, Chicago Marriott Hotel. Contact: AMA, 535 N. Dearborn St., Chicago, 60610, 312/751-6412.

Nov. 3-4 — Diet & Exercise: Synergism in Health Maintenance, sponsored by the AMA, Walt Disney World Complex, Florida, contact: AMA Department of Foods and Nutrition, 535 N. Dearborn St., Chicago, 60610.

Nov. 4 — MSMS 1981 Health Issues Conference — Stress in the Contemporary Woman, Long's Convention Center, Lansing, contact: Sherry Wellman, MSMS headquarters.

Nov. 7-8 — Fall Seminar, State of Michigan Branch, American Association of Medical Assistants, Holiday Inn, Battle Creek, contact: Caroline Rich, MSMS headquarters.

Nov. 17-19 — 1981 MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 28-Feb. 11, 1982 — MSMS/INTRAV South American Adventure, contact: Marce Ireland, MSMS headquarters.

Feb. 6-Feb 13, 1982 — MSMS/INTRAV West Indies Air/Sea Cruise, contact: Marce Ireland, MSMS headquarters.

Other meetings

Nov. 10 — The 1982 Federal Budget: Michigan Implementation, sponsored by the Michigan League for Human Services, Lansing Civic Center, contact: Michigan League for Human Services, 200 Mill Street, Lansing, 48933, 517/487-5436.

Nov. 12-13 — Conference/Training Symposium and Annual Meeting of the Michigan Association of

Microbiological Systems for the Physician's Office

- Troy Biologicals offers a variety of culture systems that enable the physician to perform a culture and sensitivity on different specimens (throat, urine, vaginal, wound, skin, etc.).
- *The Quad Plus System* is an all purpose system which includes a (1) quad plate for identification purposes, (2) a Mueller Hinton plate for sensitivity testing, (3) antibiotic discs, (4) swabs and (5) patient report pads. Pricing for the *Quad Plus System* begins at $1.99 per system. Quantity discounts are available.
- Specialized bi-plate and tri-plate systems are also available for throat and urine specimens. Troy Biologicals also offers a complete line of standard plates and tubed media, such as T.S.A. with 5% sheep's blood, E.M.B. agar, MacConkey agar, etc. Contact us for a price quote.
- A complete set-up is available upon request. Troy Biologicals carries a full line of related microbiological supplies such as incubators, loops, alcohol lamps, swabs, culturettes, disc dispensers, etc.
- A *Workshop in Clinical Microbiology* is also available to those who need additional training.
- Call for a complete price list and colored brochure.

TROY BIOLOGICALS, INC.
6107 E. Ten Mile Road • Warren, Michigan 48091
Call Collect: (313) 759-4530

ehabilitation Facilities, Hilton n, Lansing, contact: MARF, 938 ichigan National Tower, Lansing ›933.

ov. 18-20 — Special Programs 4)ecial Needs, sponsored by the ichigan Rehabilitation Association, ıirlane Manor, Dearborn, contact: ›ggy Currie, Ross Business Institute, 1700 Greenfield, Suite 273, Oak ırk, 48237, 313/968-1970.

ec. 3 — Michigan Psychiatric Soci-y Council Meeting, Recess Club, etroit, contact: Sarah Allison, ichigan Psychiatric Society, 313/ ›2-8666.

ec. 5 — Eleventh Annual Work-ıop, Michigan Speech Pathologists Clinical Practice (MSPCP), Detroit thletic Club, contact: Christine)winski, Oakwood Hospital Au-ology & Speech Pathology Dept., 3101 Oakwood Blvd., Dearborn, 3124, or 313/336-3000, ext. 517.

AMA publishes new MD opportunities

The American Medical Association's Physicians' Placement Service has announced publication of its August 1981 quarterly issues of *Opportunity Placement Register* and *Physician Placement Register*.

Opportunity Placement Register, listing currently available full-time medical practice positions throughout the United States, is designed to aid physicians who wish to relocate. *The Physician Placement Register* lists physicians seeking practice locations and is used by communities, medical organizations and institutions for help in recruiting physicians. The listings in both Registers cross geographic and specialty lines, thus making the AMA's Physicians' Placement Service the largest in the field.

Available separately from the Service are listings of positions available in U.S. possessions and foreign countries as well as information on available part-time and locum tenens (temporary replacement) positions.

There is a one-year registration fee for physicians of $35 (AMA members receive a $10 discount). Hospitals and other medical facilities are charged an annual registration fee of $95. To receive a free copy of either Register, write to Physicians' Placement Service, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
143 Courtland Avenue
Rockford, Michigan 49341
(616) 866-9395

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Oct. 15-17, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **For:** All interested physicians. **Cost: $300. Contact:** Alfred B. Swanson, MD, Blodgett Professional Building, Suite 290, 1900 Wealthy Street, S.E., Grand Rapids, 49506. **Approved for:** 19 hours of Category i Credit.

Date: Saturday's, 8:30 am to 11:30 am, Sept.-June, Orthopedic Conference. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Education. **Contact:** Dr. E. Guise (313) 876-2188. Approved for: 3 hours of Category i Credit.

Date: Wednesdays, 7:00 am to 10:00 am, Jan.-Dec. Emergency Medicine Conference Series. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Education. **Contact:** Dr. James Nowakowski (313) 876-1552. Approved for 3 hours of Category i Credit.

Date: October 17-18, "Seasons of Life: Alcoholism and Drug Abuse Knows No Age." Location: Grand Hotel, Mackinac island. **Sponsor:** Michigan Alcohol & Addiction Association. **Accrediting sponsor:** College of Human Medicine, MSU. **For:** All interested physicians. **Contact:** Diana Vella, Administrative Coordinator, Michigan Alcohol & Addiction Association, 23450 Middlebelt, Farmington Hills, 48024. (313) 474-1291. **Approved for:** 10 hours of Category I Credit.

Date: Oct. 22 & 23, "Trends in Perinatology." Location: Kalamazoo Valley Community College. **Sponsor:** Bronson Methodist Hospital Labor & Delivery and Neonatal intensive Care Unit and Southwestern Michigan Area Health Education Center. **For:** Primary care physicians, gynecologists and pediatricians. **Cost:** $40 for both days; $25 for one day. **Contact:** Carol Chaffee, RN, Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo 49007. **Approved for:** 9 hours of Category i Credit.

Date: Oct. 23-24, Computers in the Private Practice of Medicine. Location: Plymouth Hilton, 14707 Northville Road, Plymouth, MI. **Sponsor:** Heritage Hospital. **For:** interested physicians. **Cost:** $60 — Heritage Hospital physicians, $85 — other attendees. **Contact:** KK Sawhney, MD, 313/295-3431, Heritage Hospital, Taylor, Mi. Approved for 12.25 hours of Category i Credit.

Date: October 28-30, Tutorial on Cranio-Sacral Technique. Location: Kellogg Center for Continuing Education, Michigan State University. **Sponsor:** Michigan State University College of Osteopathic Medicine. **For:** D.O.s or M.D.s with prior "Basic Principles of Manual Medicine" course. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM 517/353-8822. Approved for 40 hours of Category i Credit.

Date: Wednesday, Oct. 28, 1:00 pm-9:00 pm, Gearing Up for Retirement. Location: AMA headquarters, 535 N. Dearborn, Chicago. **Sponsor:** AMA Department of Practice Management. **For:** All interested physicians and spouses. **Cost:** $100 for AMA or State/County medical Society members, $150 for non-members, (No extra fee for spouses). **Contact:** Kimberlee Watts — 312/751-6383. Approved for 4 hours of Category i Credit.

Date: Wednesdays, beginning Oct. 28, Conflict and Anxiety. Location: Ann Arbor. **Sponsor:** Michigan Psychoanalytic institute, Extension Division. **For (Specialty):** Psychiatrists and psychoanalysts. **Cost:** $100. **Contact:** Frances Shepherd, Admin. Director, MPi, 313/559-5855. **Approved For:** 12 hours of Category i Credit.

Date: Oct. 28-30, Annual Review: Problems Internal Medicine. Location: Room 2055, Education & Research Center, Henry Ford Hospita Detroit. **Sponsor:** Henry Ford Hospital. **Cos** $200. **For:** All interested physicians. **Contac** Office of Medical Education, Henry Ford Hosptal, (313) 876-1464. **Approved for:** 18 hours Category I Credit.

OCCUPATIONAL PHYSICIAN

The Detroit Edison Company is in need of an Occupational Staff Physician. Surgical or occupational background preferred but not essential. Modern facilities with an excellent working environemnt. Attractive salary and a comprehensive benefits package including five weeks paid vacations, CME credits, and National and Local Society dues.

Interested candidates should reply in strict confidence to:

Mr. Arthur C. Sedestrom, Jr.

DETROIT EDISON COMPANY

College and Professional Employment
2000 Second Avenue
Detroit, Michigan 48226

An Equal Opportunity Employer

Detroit Edison

E. H. ROWLEY COMPANY, INC.

Orthopedic & Prosthetic Appliances

A. Artificial Limbs
B. Commodes
C. Driving Controls
D. Breast Protheses
E. Hospital Beds
F. Lifts
G. Ostomy Supplies
H. Van Lifts
I. Pulsating Mattresses
J. Surgical Garments
K. Trapeze Bars
L. Walkers
M. Wheelchairs
N. Whirlpool Baths
O. Nerve Stimulators
P. Wheelchair Ramps

Please send more information about the circled items:

A B C D E F G H I J K L M N O P

Name ____________________
Address ____________________
City ____________________
State ______________ Zip __________

Tape or glue this Post-Paid Label to any envelope and mail your completed coupon to us. We pay the postage!

No postage necessary if mailed in the United States

BUSINESS REPLY LABEL
First Class Permit No. 9, Royal Oak, MI

POSTAGE WILL BE PAID BY ADDRESSEE

E.H. Rowley Company, Inc.
317 E. Fourth Street
Royal Oak, MI 48067

E. H. ROWLEY COMPANY, INC.

317 E. Fourth St., Royal Oak, MI 48067 Phone: 544-3636
11330 Woodward Ave., Detroit, MI 48202 Phone: 868-6545
G1232 North Ballenger Rd., Flint, MI 48504 Phone: 235-1981

Serving the Handicapped Since 1908

te: Oct. 28-30, Blood Coagulation: Clinical d Laboratory Aspects. Location: U-M wsley Center, Ann Arbor. **Sponsored by:** dical schools of University of Michigan and chigan State University. **For:** MDs with major erest in hemostasis. **Cost:** $215. **Contact:** Of- 9 of CME, Towsley Center, U-M, Ann Arbor, 109. (313) 764-2287. **Approved for:** 20 hours Category I Credit.

te: October 29, Preventing Occupational Dis- e. Location: Kellogg Center, Michigan State iversity. **For:** All interested physicians. **Cost:**). **Contact:** Richard Kibbey, Council on Oc- pational Safety and Health, 528 Mason Plaza, ison, 48854 (517) 676-4518. Approved for 6 urs of Category I Credit.

te: Oct. 30-Nov. 1, Topics in Anesthesiology the Eighties. Location: Grand Traverse Hil- i inn, Traverse City. **Sponsors:** Michigan So- ity of Anesthesiologists and University of chigan School of Medicine. **For:** Anes- siologists. **Contact:** Caroline Rich at MSMS adquarters. **Approved for:** 9 hours of Category redit.

te: Nov. 1-4, Fifth Annual Symposium on mputer Applications in Medical Care. Loca- n: The Sheraton Washington Hotel, Washing- 1, DC. Sponsor: George Washington Univer- y Medical Center, and numerous professional cieties, US Government agencies and univer- ies. **For:** Physicians, health care adminis- tors, biomedical scientists, engineers, and ier health care professionals. **Contact:** Janice iridge, Registrar, SCAMC — Office of CME, orge Washington University Medical Center, 00 K Street, NW, Washington, DC 20037, 2/676-4285. **Approved for:** 28 hours of Cate- ry I Credit.

te: Nov. 12-13, Clinical Oncology: Advances in the Diagnosis, Care, and Treatment of the Cancer Patient. Location: Towsley Center for Continuing Medical Education. **Sponsor:** Dept. of Postgraduate Medicine and Health Professions Education, The University of Michigan Medical School. **Cost:** $175. **Contact:** David Bruce Youel, MD, Director, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical Center, Ann Arbor, 48109. **Approved for:** 15 hours of Category I Credit.

Date: Nov. 13-15, International Symposium on Maxillofacial Trauma. Location: Detroit Plaza Hotel. **Sponsor:** American Academy of Facial Plastic and Reconstructive Surgery and the Wayne State University School of Medicine. **Cost:** $325, plus $75 for each of four workshops. **Contact:** WSU School of Medicine, Division of Continuing Medical Education, 9 B-32 DRHUHC, 4201 St. Antoine, Detroit, 48201. 313/577-1180. **Approved for:** 20.5 hours of Category I Credit.

Date: November 13-14, Twenty-Ninth Annual Symposium on Trauma. Location: Harper Hospital, Kresge Auditorium, Second Floor, 3990 John R., Detroit. **Sponsor:** Michigan Committee on Trauma of American College of Physicians. **Co-sponsor:** MI Chapter of American College of Emergency Physicians. **For:** Trauma specialists. **Cost:** $70. **Contact:** Charles E. Lucas, MD, (313) 494-3485. **Approved for:** 9 hours of Category I Credit.

Date: November 14, Symposium, "Working with Aggression." Location: Hyatt Regency Dearborn. **Sponsor:** The Michigan Psychoanalytic Society. **For:** All interested physicians. **Contact:** Jack Novick, PhD, Chairman, Program Committee, The Michigan Psychoanalytic Society, 16310 W. Twelve Mile Rd., Suite 204, Southfield, 48076. **Approved for:** 6 hours of Category I Credit.

Date: December 3-4, The Second Annual Bronson Trauma Days on "The Critically Injured Patient — A Challenge to Care". Location: Kalamazoo Valley Community College, Kalamazoo. **Co-Sponsor:** Bronson Methodist Hospital Trauma Center, SWM Systems, Inc. and Southwestern Michigan Area Health Education Center. **For:** Trauma & Emergency. **Cost:** $50 - physicians; $40.00 - nurses; $20.00 - EMT. **Contact:** Sandy Vose, Program Assistant, Bronson Trauma & Emergency Center, 252 E. Lovell, Kalamazoo, MI 49007, (616) 383-7576. **Approved for:** 13 hours of Category I Credit.

Date: Dec. 12, Michigan Society of Pathologists December Seminar. Location: Rackham Amphitheater, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **Contact:** Willys F. Mueller, MD, Department of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours Category I Credit.

Date: December 14-18, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine in conjunction with the North American Academy of Manipulative Medicine. **For:** interested DOs and MDs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM; 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Tortola, British Virgin Islands
Butterworth Hospital, Grand Rapids, Michigan Announces

The Fourth Annual British Virgin Islands Medical Conference in Tortola, British Virgin Islands

A four day educational and enjoyable experience under the direction of Ralph Blocksma, MD, and a most distinguished guest faculty!!

Dates: February 10-13, 1982

Topic: "BACK TO BASICS IN MEDICINE AND SURGERY." Brief presentations by major and minor specialists on new developments in their area. Ideal for physicians with broad interests.

Non-academic: Afternoons and evenings include many planned social and cultural events and free time to enjoy Tortola and neighboring islands.

Accommodations: to be coordinated through Celia M. Steele, Secretary for Continuing Medical Education. Special rates in effect.

For more information, please call: Celia M. Steele, Dept. of Continuing Medical Education (616) 774-1835 or 36

or Write: Butterworth Hospital, Continuing Medical Education
100 Michigan, N.E., Grand Rapids, Michigan 49503

Butterworth Hospital offers a wide variety of Continuing Medical Education Programs. Should you wish more information, please call or write:

Phone: (616) 774-1835 or 36

Address: Dept. of Continuing Medical Education, 100 Michigan, N.E., Grand Rapids, Michigan 49503.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

WANTED: MEDICAL OPTHALMOLOGIST to join established, growing practice in beautiful Lake Tahoe — Reno, Nevada area. Excellent climate and year-round recreational facilities. Will consider full or part time or retired physician. Contact Karen Grodowitz, MS — Executive Director — Reno Eye Clinic, 1530 E. 6th St., Reno, NV. 89512 (702) 329-1389.

PSYCHIATRIST — Full time staff psychiatrist position available in the Outpatient Mental Health Clinic. Responsibilities include outpatient treatment and student teaching. This is a 458 bed acute care facility located in suburban Detroit. Board certification preferred. Approximate salary range: low to mid-fifties. Liberal benefits offered. Send vitae to M. Roberts, MD, Director, Mental Health Service, Providence Hospital, 16001 W. Nine Mile Road, PO Box 2043, Southfield, Michigan 48037.

GENERAL SURGEON — Board Certified — US trained. Preferably with additional training in vascular and endoscopy. To join busy surgical practice in Michigan's UP. Send CV and references with initial reply to R. Bergman, MD, FACS, 101 Doctors Park, Escanaba, MI 49829.

ARIZONA EMERGENCY MEDICINE: Directorship and clinical positions available for career-oriented emergency physicians in sunny western Arizona resort town. Excellent income, paid professional liability insurance, and flexible scheduling without on-call duties. For details call Lillian Asato toll-free, 1-800-421-6655; or send credentials in confidence to 606 Wilshire Boulevard, Suite 504, Santa Monica, CA 90401.

WE ARE a multi-specialty medical center with a position available for an internist on a part time basis. We have a modern laboratory, x-ray dept. and a complete pharmacy. Please contact Mrs. Bond, Garden City Medical Center, 6033 Middlebelt Road, Garden City, MI 48135.

MEDICAL LABORATORY Technician, Excrement Tester — measure and aliquot human excrement. Perform other laboratory procedures — high voltage electrophoresis, chromatography, scintillation counting — using stool homogenizer, centrifuges, etc. Requirements: Two years college training in Chemistry/Biology. Two years experience in related occupation with Biochemistry laboratory experience. Contact: Clinical Research Center, University Hospital, University of Michigan, Box 55, W-4642 Main Hospital, Ann Arbor, MI 48109.

EIGHT MAN MULTI-SPECIALITY GROUP consisting of five family physicians seeking a board certified or board eligible Family Physician with a desire for obstetrics to join professional corporation serving a drawing population of 45,000. 200 bed hospital one mile from clinic. Excellent salary, variety of fringe benefits, and opportunity to become a partner after one year. Alpena located in Northern Michigan on a bay of Lake Huron and rates very high in outdoor recreation. Please send inquiries and C. V. to Barbara Barkley, Medical Arts Clinic, P.C., 211 Long Rapids Road, Alpena, MI 49707.

ARIZONA EMERGENCY MEDICINE: Directorship and clinical positions available for career-oriented emergency physicians in sunny western Arizona resort town. Excellent income, paid professional liability insurance, and flexible scheduling without on-call duties. For details call Lillian Asato toll-free, 1-800-421-6655; or send credentials in confidence to 606 Wilshire Boulevard, Suite 504, Santa Monica, CA 90401.

EMERGENCY MEDICAL POSITIONS — Emergency Consultants, Inc. has Emergency Medicine opportunities available in resort and metropolitan locations. 60 hospitals in 12 states are currently serviced. Benefits include competitive salaries, paid malpractice insurance, and flexible scheduling. For further information contact: Emergency Consultants, Inc., 2240 South Airport Road, Suite 115, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OPHTHALMOLOGIST WANTED to do office ophthalmology two or three days a week in well-equipped suburban office outside of Detroit. Excellent terms. Reply to Box 19, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

OPHTHALMOLOGIST FULL-TIME, outstanding opportunity to join busy practice in suburb of Detroit. Reply to Box 20, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

PHYSICIANS NEEDED IN ROGERS CITY AND POSEN, MICHIGAN. Excellent opportunity for physicians seeking a wide variety of financially rewarding professional experiences. Located near Lake Huron with excellent outdoor and family lifestyle. Attractive income guarantee in solo or group practice settings. If interested, call collect to: Evans Calas, Assistant Administrator, Rogers City Hospital, (517) 734-2151.

CALIFORNIA-DIRECTOR POSITIONS AVAILABLE. Emergency medicine physicians needed for rural Northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit-sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610. 415/832-6400.

PART-TIME PHYSICIAN needed to do routine physicals to assess donor suitability for plasmapheresis. Good position for older physician looking to slow down. Malpractice coverage provided. Contact Thomas Anderson at American Plasma Management, Kalamazoo, MI. Phone 616/381-0086.

Positions with The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primar interested in board certified or board eligit internists with cardiology background. Offi locations in Southfield, Lansing, and Traver City. Also considering an office in Kalamazc Salary in 50's with approximately 40% frin benefits. An equal opportunity employer. inquiries treated confidentially. For further c tails please write: Disability Determinati Service, P.O. Box 30011, Lansing, MI 48909, call collect: Harry D. Nesmith, MD, Chief Me cal Consultant (517) 373-7830. In Michigan, c toll free 1-800-292-2710.

Positions wanted

EXPERIENCED medical receptionist is seeki employment in doctor's office. Please ca 517/372-1844, ask for Tammy.

OPTICAL DISPENSER, over thirty years exp rience, would like position with opthalmolo office. Available November 1st, Abbe A. Le 23620 Wildwood, Oak Park, MI. Phone 31 967-3518.

STUDENT PHYSICIAN SEEKS Communi Sponsorship: Second year student at Ne York College of Osteopathic Medicine in nee of financial assistance in return for service Please reply to: Ms. Bonnie Anne Salbert, 9 Grand Blvd., Westbury, New York 11590.

Miscellaneous

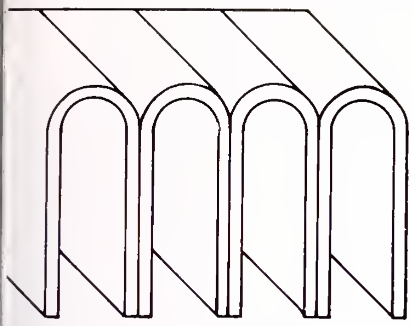
RECREATION/INVESTMENT Property Michigan Upper Peninsula. 45+ acres with a proximately 600 ft. sand beach frontage Lake Michigan. Private asphalt drive, 4 year o American Timber Home Chalet — 4 bedroom, bath — full basement with large family/recre tion room and wet bar. Front deck, all-electri Jen-Aire Kitchen. 3-car garage with 2 older o buildings (cottage/boat house). 15 miles sou of Escanaba on M-35. Excellent financing pla $180,000 total. Includes many extras. Ca 906-786-8822 if you wish more details.

BATTLE CREEK, Michigan — 4300 square fo Medical-Dental facility. Available in October November, 1981. Located within two minut drive of two LARGE HOSPITALS. Country se ting with abundant parking. Attractively d signed and landscaped. Call Ron Kuhn, 61 968-5200 days, 616-979-1810 evenings.

COMPHEALTH — Locum Tenens — Physiciar covering physicians, nationwide, all specia ties. We provide cost effective quality care. Ca us day or night. T.C. Kolff, MD, Presider CompHealth, 175 W. 200 S., Salt Lake Cit Utah 84101 (801) 532-1200.

WE HAVE VARIOUS QUANTITIES OF MED CAL EQUIPMENT available in excellent conc tion. We buy, sell, trade, move and repair. Ne

)EATHS



/iola G. Brekke, MD
Veilsville, MN

'iola G. Brekke, MD, died June 20 at he age of 76. Doctor Brekke, formerly of Grosse Pointe, was the first woman elected president of the Michigan Pathological Society in 961. She was on the staff of Highland Park General Hospital, and in 956 was voted "Medical Woman of he Year" by the Michigan branch of he American Medical Women's Association. Doctor Brekke received her pre-med education at the University of Michigan, where she was elected o Phi Beta Kappa, and earned her MD at Wayne State University in 941. A former trustee of the Michigan Cancer Registry, Doctor Brekke was also a former advisor to the MSMS Maternal Health Committee and to the Michigan Society of Medical Technologists. Doctor Brekke was isted in the premier edition of 'Who's Who of American Women."

Frances M. Choate, MD
Saginaw

Frances M. Choate, MD, passed away July 30 at the age of 65. She received her AB and MD degrees from the University of Michigan. Doctor Choate practiced internal medicine in Saginaw from 1951 until her retirement in 1978. She was a member of the Saginaw County Medical Society, and was on the Board of Directors of St. Francis Nursing Home, Saginaw.

Maurice M. Silverman, MD
Southfield

Maurice M. Silverman, MD, died July 14. He was 76. Doctor Silverman received his BS in medicine from the University of Michigan, and his MD in 1930 from the Detroit College of Medicine. He was affiliated with Mt. Carmel Mercy Hospital of Detroit, and was a member of the International College of Surgeons and Phi Lambda Kappa medical fraternity.

---

equipment also available. Call Doctor Medical Resale, (313) 569-4407, 9 a.m. to 9 p.m.

OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

SANDRA W. COCHRAN, MEDICAL ILLUSTRATOR. Medical illustration available, from detailed realistic renderings to simple diagrams, graphic design and biophotography. For quality illustrations at the lowest cost, call (313) 652-2547, or write 1163 Ironwood Court, Apt. 104, Rochester, Michigan 48063.

FOR SALE: all brick 4 bedroom, 2 bath home, beautiful private location, 2½ acres, attached 2 car garage, basement rec room with fireplace, patio, gas furnace, central air, 330 ft. frontage on Raisin River, spring fed lake, swim — fish, good schools, 8 minutes to good local hospital, approx. 30 miles to Ann Arbor. Terms: land contract. Write C. Trickey, 9431 Tonneberger, Tecumseh, 49286.

IREX SYSTEMS II M-mode Echocardiogram Machine. Portable, integrated unit including a strip chart recorder, monitor oscilloscope and main control panel. The recorder produces permanent black and white records using a therman processor. Also includes a 12 lead ECG capability. Machine under a nine month warranty and includes a 2.25 MHZ 13mm quarterwave transducer. Price — $17,500 + tax. For further information call (313) 733-0790.

HILTON HEAD ISLAND, SC. Ocean Villa, Captain's Cove in Palmetto Dunes Resort. Luxurious new villa, 150 yds from beach. Lagoon backyard, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, pool, fishing, canoeing, biking, etc. Weekly, monthly. Call or write, (313) 695-0356, 6236 Kings Crown Rd., Grand Blanc, MI 48439.

Thanks to our advertisers

Ad Council	546
Advance Medical Research	563
Blue Cross/Blue Shield	537
Brown Pharmaceuticals	521
Burroughs Wellcome	523
Butterworth Hospital	569
Carlton Lush Investments	563
CBC Labs	539
Dart Medical	530, 531
Detroit Edison	568
Diamond Trading Group	565
E. H. Rowley	568
Eli Lilly	525
Gamma Analysis	561
I. C. System	555
Insight at Colombiere	558
International Diamond Corporation	551
Kaplan Education Center	564
Medical Protective	567
Merrell Dow	548, 549
Michigan Bell	553
Michigan Physicians Mutual Liability Co.	543
MSMS Annual Scientific Meeting	IFC
MSMS Committee to Assist Impaired Physicians	552
National Medical Enterprises	557
Physicians Insurance	533
Roche	514, 515, 516, 546, 547, IBC, BC
Smith, Kline & French	545
So. Macomb Thyroidology	554
Stratton Cheeseman	559
Troy Biologicals	566
Wyeth	527, 528

PRESIDENT'S PAGE

Welcoming new students to the medical family

James D. Fryfogle, MD, MSMS president

August was an extremely busy month for me. My surgical schedule did not allow much time for other activities.

But I did have the very enjoyable opportunity to address the 256 members of the incoming freshman class at Wayne State University August 28. I spoke as MSMS president, on behalf of all of us members of organized medicine.

(Editor's note: Several reports on the incoming WSU students' good responses to Doctor Fryfogle's warm remarks have been heard at MSMS headquarters since.)

Here's pretty much how it went:

Michigan State Medical Society welcomes you and congratulates you on your first step along the "doctor path." The 9,800 doctors who make up this organization invite you to work with them and our talented staff to preserve and promote ethical medicine in our state.

The MSMS works with every branch of medicine. It:

1. Provides services in post graduate education. You know that today's doctor still must go to classes and get 50 accredited hours every year to maintain his license to practice.

2. Provides help in how to run your office with business management courses, to organize personal finances and retirement plans.

3. Acts as your legislative voice in Lansing and Washington. This is a busy and important activity in today's world.

4. And MSMS even runs its own malpractice insurance company that protects you and your patients from the very real hazards of today's practice of medicine.

A student section in the MSMS House of Delegates and student membership in MSMS has been approved and is an active part of our society.

We need you — you need us — we need each other. So along with all the medical terminology you'll be hearing, take a look at Robert's Rules of Order — it's a tool you'll need.

Forty-two years ago I sat in a similar orientation seat — one of 58 students who were awed, anxious, eager and a little afraid. Medical students then, as now, came in all sizes and shapes, all races and colors, with different backgrounds and philosophies. The single constant feature of all medical students, is what they feel in their hearts about the practice of medicine: "Oh, Lord, let me be a doctor, a good doctor."

And it never changes.

What I'd like you to do is look at each other — turn around and look. Today you don't even know each other's names. Before you hang up your shingle, you will have shared with each other almost every basic human emotion.

When, as a doctor, you assume the responsibility for a patient's life, it becomes very lonely at decision-making time. There are only two people you can trust — yourself and your fellow physician.

Last night, at Mt. Carmel, I sat on the bed of a doctor friend of many years, who is recovering from his second kidney transplant. I then went down a floor to see a neurosurgeon just recovering from a stress bleed. We talked about doctors caring for each other.

This, in the broadest sense, is what the Michigan State Medical Society is all about.

I agree with Doctor Mack. You are very special people. You have been selected to train for a special job — patient care.

Let me add to your burden. First, there is a difference between patient care and caring for people. And, second, in today's world of medicine, the doctor must act as an advocate for the patient. Everybody from the government to the insurance companies and the Reader's Digest will tell you how the patient should be treated. But only you, the doctor, will know.

So you must speak out, in defense of what's right for your patients.

Enough! Again, welcome! Be good to each other. Be caring doctors and advocates for your patients. Come and join us.

MICHIGAN MEDICINE

November 1981 Vol. 80, No. 32

Good health promotion

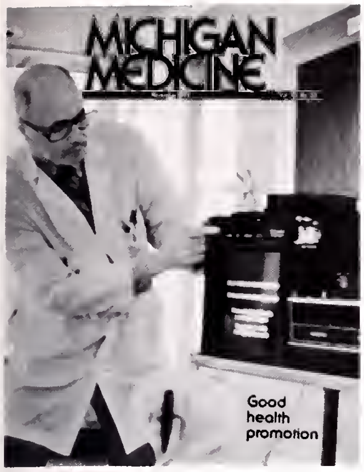
COLLEGE OF PHYSICIANS
OF PHILA HIA
DEC 3 - 1

Who to call at MSMS headquarters

Advertising (in *Michigan Medicine)*	Sheri Greenhoe
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Facilities	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Marce Ireland
Category I Calendar (for *Michigan Medicine)*	Sheri Greenhoe
MSMS-Sponsored Conferences	Sherry Fent
Dues Payments	Jerry Trahan
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	John Richards
Health Planning	Dennis Paradis
Impaired Physicians	Marcelyn Ireland
Jail Health Project	Dick Campau
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose Ellen Vinocur Potash
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
Medical Assistants	Caroline Rich
Medical Auxiliary	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Sheri Greenhoe
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Vi Heins
Michigan Doctors Political Action Committee	Kevin Kelly
Michigan Medicine (MSMS Journal)	Judy Marr
Michigan Society of Anesthesiologists	Caroline Rich
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Facilities	Marce Ireland
MSMS News Relations	Mert Scholten
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
Physician Hospital Relations	Bill Madigan
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	Bill Madigan
PSRO	Sherry Wellman
Specialty Societies	
Information	Nancy Wimmer
Committee of Specialty Society Presidents	
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society
120 West Saginaw (Box 950)
East Lansing, MI 48823

MSMS PHONE: 517/337-1351



On this month's cover, Richard L. Hatton, MD, of Okemos tunes in his own video tape on the birth and initial examination of a newborn baby. His extensive in office patient education materials and equipment highlight our special report on good health promotion efforts of Michigan physicians. **(Photo by Mert Scholten, MSMS staff)**

MICHIGAN MEDICINE

November 1981, Volume 80, No. 32

Special report

579 The understanding and participation of well-informed patients is the goal of MSMS members and other physicians around Michigan for whom good health promotion is increasingly important. The AMA and MSMS are working toward this goal and are ready to help physicians plan programs for the patients they see in their offices. Articles in this special report describe some enlightened physicians' individual efforts, AMA and MSMS programs, and the philosophy of one involved family physician's highly-developed patient education program; Charles R. Downs, Richard L. Hatton, MD

Features

591 Does the new federalism mean more flexibility for the states? MSMS finds the answer is yes and no; Dennis M. Paradis and Sherry N. Wellman

594 MSMS reports on legislation affecting medicine in Michigan; Ellen Vinocur Potash

598 Legislative profile: Sen. William Sederburg; Willah Weddon

603 Hospital Performance Measurements Study reveals marked differences in use and costs of Michigan hospitals; Martha Climo

606 Michigan's new public health director addresses MSMS Council; Bailus Walker Jr., PhD

614 MSU's entering medical class over 50 percent female this year; Nan Houston

618 Behind the MSMS desk reference cards; Roger Postmus, MD

619 Maternal Health Desk Reference Card No. 7: Hypertensive Diseases of Pregnancy

624 Latest data from MSMS malpractice claims study; Deborah Zannoth

Departments

575 Letters

588 Finances: The Economic Recovery Tax Act

628 Newsfronts

630 Meetings

632 News

634 Category I meetings

634 Ad index

635 New members

636 Deaths

637 Classified

638 Medico-Legal

MSMS honors two special people

Her friends on the MSMS Maternal Health Committee had roses and thank yous for Helen Schulte on her retirement recently from MSMS. Helen was staff liaison to the committee and its annual Maternal Health Conference during most of her 35 years with MSMS, though at her retirement she was executive secretary to the Michigan Psychiatric Society. Maternal Health Committee members invited Ms. Schulte to dinner following a regular meeting, paid her tribute and presented her with gifts. From left, her well-wishers include Lee B. Stevenson, MD, committee chairman; William T. Unkefer, MD; John W. Hallitt, MD; James E. Harryman, MD, and Hermann A. Ziel, MD.

Harbor Beach family physician Charles W. Oakes, MD, left, is the first recipient of the new MSMS Frederick and Besse Moulton Plessner Memorial Award. The award is designated for the physician who best exemplifies the practice and ethics of a rural country practitioner, and is presented also for service to the indigent and to the community. MSMS President James D. Fryfogle, MD, right, presented the award to Doctor Oakes during the Sept. 9 MSMS Council meeting at MSMS headquarters.

Doctor Oakes replies:

I want to thank Doctor Fryfogle and the Council of MSMS in awarding me the first Plessner Award. I was surprised and pleased to receive the award.

I am adding this award to the Jennie Oakes Nursing scholarship fund, hoping to build it up so that two deserving girls will have their tuition and books paid for in their first year of nursing education.

I have enjoyed working with you and members of the Council in the house of Delegates the past 38 years.

My best regard to all of you,

Sincerely,
C.W. Oakes MD
Harbor Beach

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
John R. Ylvisaker, MD, Pontiac

Editor
Judith Marr

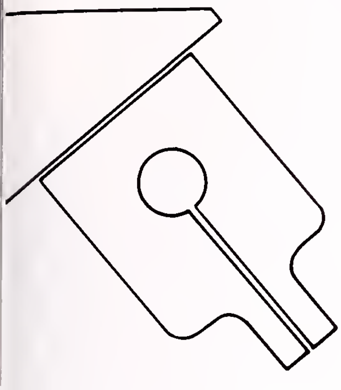
Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $20.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. ©1981 Michigan State Medical Society.

LETTERS



Infant mortality

It is a well-known fact that infant mortality rates have been continually decreasing in the United States over the past 20 years. These rates have also been decreasing in Michigan, and more specifically, in Genesee County; however, Genesee County consistently has the highest infant mortality rate in the state. Since 1970, the infant mortality rate for the State of Michigan has fallen from 20.3 to 12.9 (1979), whereas the rate for Genesee County for the same period fell from 21.1 to 15.5

Previous studies which have focused on this problem in Genesee County suggest that cause-specific mortality varies by age of infant. Immaturity, respiratory illness, accidents, SIDS, and congenital anomalies appear to contribute to the higher Genesee County rate at various ages of the infant. For some of these causes of death, the white infant mortality rate is notably higher than the black infant rate.

The high Genesee County infant mortality rate has been the concern of Michigan public health officials at both the state and county levels. Efforts to examine the infant mortality problem in Genesee County are underway at the Division of Maternal and Infant Health of the Michigan Department of Public Health.

I am in charge of a parallel effort under a University of Michigan-Flint research grant to study this problem. Our research includes record-linking of birth and death certificates over a three-year period and examining a smaller geographic area of the mother's residence than has previously been studied.

This more specific residential identification is expected to advance knowledge and offer more clues as to what is peculiar about Genesee County. This information will certainly answer some questions; however, this epidemiological study would greatly benefit from the insights available from the physicians who see these infants on a day-to-day basis.

Epidemiological research provides clues to etiology based on distribution patterns. The Flint-based study will shed more light than has previously been available. What is also needed are insights from clinicians as to what factors could account for this unexplained higher infant death rate in Genesee County. Suggestions or insights are welcomed. Please send responses to:

Dr. Suzanne Selig, PhD, MPH
Director, Health Care Program
University of Michigan-Flint
Flint 48503

Class!

Terrific cover, September! And the cover 2 promo page is great, too, and the "what to expect" page, and the separate scientific program booklet, and so forth and so on through all you do. Everything you do has *class*.

Three cheers!
Ann Gray
Managing Editor
Virginia Medical

The Letters column provides MSMS members with a means to express their opinions and viewpoints. If you have an item you would like brought before your fellow practitioners, please submit it to Letters, *Michigan Medicine*, 120 W. Saginaw St., East Lansing, MI 48823. Letters should not exceed 250 words. The right to abstract or edit is reserved by the editors and Publications Committee.

Pancreatic cancer

The National Pancreatic Cancer Project was funded by the National Cancer Institute in 1975 to stimulate research related to pancreatic cancer, now the fourth cause of death from cancer in the United States.

Patients, and families of patients with pancreatic cancer, often contact the National Cancer Institute, from which they are referred to this project. In a determined effort to avoid any interference with the patient-physician relationship, I tell patients that I will share whatever information I have with the responsible physician. But I do not voice any opinions directly to the patient or to the patient's family.

To improve the care of these patients, we try to maintain current information on new approaches to the diagnosis and treatment of pancreatic cancer and the names of individuals or institutions participating in advanced treatment protocols. We have information about certain institutions with highly specialized facilities, some of which provide transportation and medical care at no cost to the patient. This kind of information I am happy to share with any physician. The final recommendation for a patient's treatment by any modality must come from the primary physician.

The purpose of this letter is to make this information available to the constituent members of the Michigan State Medical Society. A call to me would allow me to share information that might help the patient and might allow me to suggest some more advanced treatment program, often available in geographic proximity to the patient.

Isodore Cohn, Jr., MD
Project Director
National Pancreatic Cancer Project
Louisiana State University
Medical Center
New Orleans 70112

THE PATIENT THINKS
HE HAS HEART TROUBLE...

...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® ⓘⓥ

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

ROCHE®

Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500.* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701
†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

ROCHE®
ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

How to establish your practice...

painlessly.

At National Medical Enterprises, we've had a lot of experience in establishing and building a practice.

We can offer you a choice of over 60 well equipped acute care hospitals coast to coast. We can offer you selected financial assistance. We can offer you professional management consulting.

We know what you want and how to get it for you.

So if you're a Primary Care Physician interested in a partnership, group or a solo practice, contact NME today.

We'll help you establish your practice...painlessly.

For further information, contact:
Raymond C. Pruitt, Director Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.

Call Toll-Free 800-421-7470
or collect (213) 479-5526.

NATIONAL MEDICAL ENTERPRISES, INC. nme

"The Total Health Care Company."
An Equal Opportunity Employer M/F

SPECIAL REPORT

Michigan physicians learning health promotion makes them more effective

By Charles R. Downs
East Lansing

Suppose garage service managers told their customers how to keep their cars running better? Not just in a cursory way, but in careful, explicit language geared to the customer's level of understanding? Suppose they went even further and said:

"Look here, the reason you are having trouble is your bad driving habits. You race and then slam to a halt. You don't change your oil regularly and you are always letting your clutch slip. If you don't shape up and take responsibility for your own machine, there isn't much I can do to help you. You'll pay and pay and pay for service and might end up losing your car to the junkman."

Chances are such a service manager might be thought a little mad, if not by his customers, at least by his peers who would see that kind of approach as the road to financial ruin.

But the chances also are that his efforts to educate his customers would help them improve their automobiles' conditions and longevity, and would earn the garage manager his customers' respect, gratitude and loyalty. That is increasingly the way doctors around the country are helping their patients. And the patients as well as health professionals generally, are applauding their efforts.

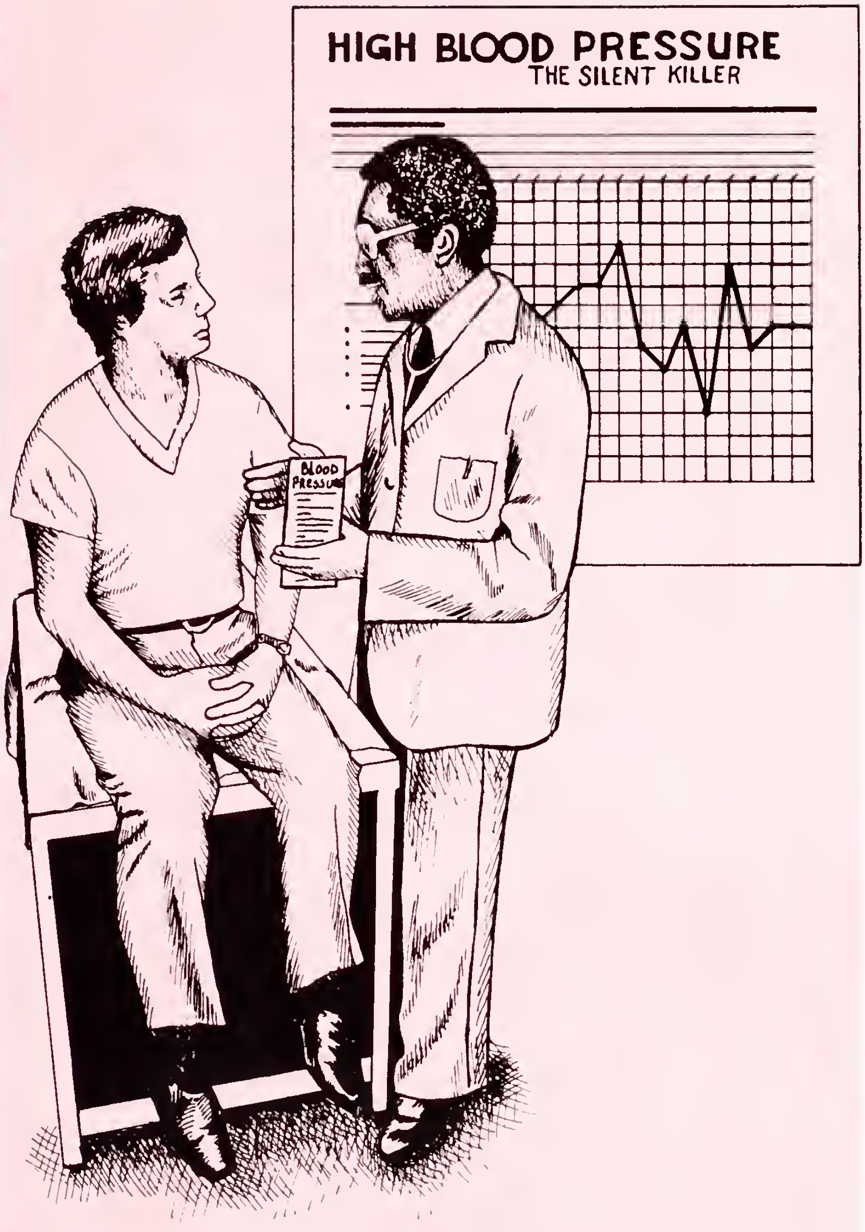
What these doctors are doing goes by many names: health education, preventive medicine, holistic medicine, well care, etc. The emerging generic term for all such activities appears to be *health promotion*.

For many doctors, health promotion is nothing new; they have always done it. But the consensus of people who pay attention to such things is that more physicians are doing more health promotion and doing it more extensively, thoughtfully and deliberately.

One of these observers is

Mr. Downs is a free-lance writer.

Continued on page 581



Blue Pencil sketch

AMA and MSMS expanding health education programs

The current boom in health promotion finds many physicians, as well as local and state medical societies, wondering what their respective roles should be.

They are looking to the AMA for help. And William Carlyon, PhD, director of the AMA Department of Health Education, is trying to provide it. He and his staff, which is being expanded, are currently providing consultation service. The AMA is installing a computer to provide an information clearing house for health promotion information.

In the near future, Doctor Carlyon expects to have computer sorted and categorized information on sources of expertise and other areas relevant to the needs of state and local societies.

AMA also plans to offer health information directly to physicians and hospitals throughout the U.S. The idea is to enable health professionals to directly access banks of information on what is now known about a variety of health problems.

MSMS, too, is committing itself to greater efforts to help the public achieve and maintain good health. In addition, the goal is to encourage the public to enter into a partnership with physicians to share the responsibility for good health maintenance.

Since 1979, the MSMS House of Delegates has committed substantial funds to an invigorated MSMS public relations program, led by the MSMS Committee on Public Service. Chairman is Robert D. Burton, MD, Grand Rapids.

Part of the public service program is to develop patient education materials. These include public service TV and radio spots to encourage people to establish a permanent relationship with a family physician, rather than waiting for illness to strike and then having to visit the emergency room.

MSMS sends medical news features on medical topics and specialties to all Michigan papers every two weeks, and 40 to 50 of the newspapers are using the service.

This fall, a massive distribution is underway of a new MSMS brochure, "If Illness Strikes While You're Away." This brochure provides travelers in Michigan with first aid information and directions to obtaining professional medical help. It is being disseminated through physicians' offices and by the Michigan Transportation Department.

MSMS released in October a half-hour, made-for-cable television program, "Has Anyone Called the Doctor?" The film is to help improve public understanding of medical care in the 1980s.

In addition, MSMS is distributing a poster to raquetball/handball courts throughout the state to remind players to wear protective eyewear.

"If you were to ask me to describe the MSMS public service goal in a single sentence," says Doctor Burton, "I'd say it is to educate our 'publics' on medical matters affecting their lives and health."

Arnold Relman, MD, editor, *New England Journal of Medicine*, commented on the subject in the Jan. 8, 1981 issue of his magazine: "Everyone agrees that we need the understanding and participation of a well-informed public if we are to continue to improve the nation's health and our health care system."

William Carlyon, director of the AMA Department of Health Education.

"We have little hard data," he points out, "but there is no doubt that health promotion has been steadily increasing since the report of the President's Committee on Health Education in 1972.

"The whole notion that life styles affect health and, therefore, that health can be improved by altering life styles is having a major impact," says Doctor Carlyon.

"Physicians know they can treat illness for 24 hours a day and never catch up. Health promotion makes them more effective.

"Doctors should never give up on diagnosis and treatment. But much of what they are diagnosing and treating is the result of life styles. And they need to realize they can affect those life styles in constructive ways."

The office approach

Physicians are approaching health promotion in a variety of ways, depending upon their specialties, personal perceptions and talents.

MSMS President-elect James H. Tisdel, MD and partners in their Port Huron obstetrics/gynecology practice rely heavily on the use of self-instructional television tapes. Patients view them on simple-to-operate video tape players in the doctors' office.

Although video tapes can be used hundreds of times, "they keep wearing out," says Dr. Tisdel. "Some are used eight to 10 times a day."

Many companies are making and vigorously marketing a wide range of self-instruction tapes. The ones Dr. Tisdel provides for his patients are designed to help laypersons understand such subjects as breast self-examination, hysterectomies, Caesarean sections and menarche.

Doctor Tisdel says the tapes are usually much more effective than what he might tell a patient, particularly his less literate and less attentive patients.

"When you explain matters to some patients," says Doctor Tisdel, "they say, 'Sure, sure, I understand.' And then they promptly forget even if they ever really understood. With the tapes, retention is much better."

Dr. Tisdel also finds group instruction of expectant mothers helpful, particularly in Lamaze classes. Most of this teaching is done by nurses and other health professionals, but he contends that it is important for physicians to take part.

In Southfield, George Dean, MD, a past president of the Michigan Academy of Family Physicians, recently initiated nutritional counseling as an integral part of his practice. He does a health hazard appraisal and a diet history when he interviews patients. He then analyzes the information and formulates a diet tailored to the patient's health needs and taking economic, cultural and social factors into account.

The patient is asked to keep a diet diary for at least one month and to schedule a return visit. He is also doing diet group therapy with small groups of patients who are on the same diet.

Zeeland urologist Bernard Meeuwsen, MD, also is involved in health promotion, but of a different sort. Last spring, he became corporate medical director of the 3,000-employee Herman Miller, Inc. furniture firm. He now is on his way to developing a model program emphasizing making employees more productive by keeping them healthy.

This is being accomplished in several ways including physical examinations, emergency medical care, safety engineering, toxicological studies, health seminars, and counseling services for employees who need psychological therapy.

Another urologist, Vernon C. Urich, MD, of Flint, extends health promotion beyond his office by taking an active role in health education programs such as a seven-week series on common medical problems of the elderly. Writing earlier this year in *Michigan Hospitals*, Doctor Urich says such programs not only increase knowledge, but also decrease apprehension.

"Immense series success," he points out, "can be attributed to physician enthusiasm and the inquisitive nature, warm reception and general interest of the audience."

Still another approach to health promotion is typified by a national organization known as DOC, for "Doctors Ought to Care." An Ann Arbor chapter was recently formed as part of a research project in family practice, to investigate whether counter-advertising and social support might limit teenage smoking.

"The question," says Scott Frank, MD, resident physician in family practice at the University of Michigan Medical School, "is not why people smoke but why people start smoking."

Using the national DOC ideas, Dr. Frank has started an anti-smoking campaign using the Madison Avenue techniques of the tobacco industry. A typical ad shows an attractive woman saying, "Do you really think I would allow tobacco smoke in these lungs?" or "Taste me, I quit."

The medical school scene

At Michigan State University, the College of Human Medicine faculty is carrying on a health promotion program to teach medical students to assess their individual health situations and learn how to cut the risk of heart disease.

Directed by Albert Sparrow, MD, professor of pediatrics and human development, the program focuses on monitoring the life styles, nutrition and exercise of the students throughout their college years, with follow-up after they earn their medical degrees and enter practice. Doctor Sparrow says the prevention message should follow the future doctors into their practice of medicine and eventually make its way to their patients.

One noticeable, and unexpected, result is that the faculty themselves are starting to take better care of themselves in order to serve as examples for the students, says Roy J. Gerard, MD, chairperson of the Department of Family Medicine at MSU.

Health promotion is an integral part of the curriculum at MSU, says Doctor Gerard. He points out that when MSU students learn to take histories, they learn to assess the patient's life style. This includes making note of risk factors and the patient's pattern of using health care services.

Students also are taught to discuss the patient's life style during the closing interview and specifically identify what the patient needs to do

Continued on page 586

There are many benefits for doctor with good patient education programs

By Richard L. Hatton, MD
Okemos

Doctor Hatton adjusts video monitor for a patient's benefit.

Traditionally a patient's visit to the doctor's office was conducted in a paternalistic setting. The symptoms were presented to the physician, who gathered information about them via a question, answer, and discussion period. Subsequently, the patient was examined and a program presented to resolve or further delineate the problem.

This program consisted of direct treatment if the diagnosis was apparent, or additional laboratory and/or radiologic investigation if the problem was more obscure. Ultimately, the patient was given a complete therapeutic plan and followed it to its termination.

During this entire process the patient had little input regarding what was being done, and usually was given as brief an explanation as possible pertaining to the reason(s).

In recent years a gradual but increasing awareness has been felt by the medical community to provide more patient education. Patients expect this information at all levels of contact with professional medicine. The physician's concerns are time, the patient's psychological set and the breadth and depth of the information given.

Paramount in this process is the amount of effort and attention the doctor or his designate will give to the educational experience. The patient's reaction depends upon the impression of importance and degree of sincerety he feels the physician (or counterpart) places on the subject and content of the material.

A second factor of great import is the feeling of partnership the patient has with the doctor in achieving the goal(s) of these programs. The stronger the patient's sensation of working together, the greater the prospect of his involvement and likelihood of success.

Implicit in this educational process is the need for materials to be used so that clear, concise, and factual information is given the patient. This instructional presentation will be more effective as the number of sensory input sites is increased.

Hence, the utilization of printed material, audio programs, and visual data enhance the learning process. In this era of rapidly expanding knowledge it is very important to keep the information current by periodic revisions.

A myriad of printed materials is available. It is the responsibility of the physician to choose carefully those publications which succinctly and clearly address a subject. Many times this may require editing several offerings and incorporating personal additions for a useful teaching instrument. Such materials frequently lose significant impact if they merely are presented to the patient with the suggestion "read this" or "look this over."

While the use of reading materials is most convenient for the physician, it isn't uncommon to find a patient who learns faster and with more retention when another avenue of input is used. Audio cassettes can be of immeasurable help. This is especially true when the physician makes his own tapes. Transference is remarkable when a patient listens to "his doctor" provide medical information. The combination of printed and auditory material gives a significant added dimension for a patient's education. The cassettes can be used

Continued on page 584

Doctor Hatton is a general practitioner, and is recipient of awards for patient education materials from the American Medical Association, Michigan Academy of Family Physicians, American Osteopathic Association and American Occupational Health Association.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Here are Doctor Hatton's programs:

Doctor Hatton must certainly be among the most active of Michigan physicians in the area of patient education programs and materials. The recipient of honors and recognition from several national organizations, he is a good model for other Michigan physicians as they expand their own educational services to patients.

Here is a list of some of Doctor Hatton's patient educational activities:

1) Teaching clinics for expectant mothers, for new mothers, for cancer patients and, being developed, for diabetes and cardiac patients. Each of these clinics is presented with a combination of discussion with active patients, video tapes and printed materials.

2) Breast self-examination clinics for the public and to train other professionals to teach the technique.

3) Video tapes for use by and with patients in the office.

4) Audio-visual diagrams and presentations.

5) Plastic models of the human body for demonstration.

6) Printed materials including atlases, brochures and oversized volumes of anatomical drawings.

---

with visual aids (eg. color slides) as well.

This opens a whole new venue. These programs are commercially available. However, the physician who creates his own adds a parameter that patients appreciate and respond to positively. Their attention is greater and retention better because they identify more closely with their doctor. In addition, the content of the material can be controlled, enabling the doctor to stress features he deems important.

These same factors hold true when the dynamic process of movies or television is used. Both are an excellent resource for patient education. Patients are very familiar with these modalities in their private lives and quickly accept them in a learning experience.

The added capability of motion markedly broadens instructional horizons. This is particularly true when demonstrations of "how to do" something aid patient understanding. Those physicians who like to make home movies could easily utilize one of these modalities to great advantage. The concern about cost has been successfully addressed in recent years and it is now possible to utilize either media for a reasonable amount.

Patient education properly begins in the doctor's office. The degree of physician involvement is directly proportional to the level of interest in and the perceived value of educational information provided patients. The patient will become increasingly involved as he senses the importance the doctor is giving these programs and exhibits a willingness to have the patient be a partner in achieving educational and/or therapeutic goals.

Although individual sessions are helpful, group work is ideal. This enables teaching materials to be used to maximum advantage. Groups can be as small as three; but, more ideally a group of eight to 10 produces best results. The use of teaching materials followed by a meeting led by the physician enables control over the subject matter and "sets" the patient psychologically for the discussion. The physician also enjoys the benefits of one discussion providing instruction for several. Patients learn more in a shorter time due to group interplay and support, coupled with their physician acting as a counselor and an informational source.

Timing of the meetings and their length are important considerations. Patients have other obligations and responsibilities. The physician and his staff should keep these factors in mind. Attention spans are longer, concentration and retention greater when participants are not burdened with too many excessive external distractions.

The meeting site is also very important. The room should be adequate in size, seating comfortable, and arranged so members of the group can see each other and the physician easily. The decor of the room should be conducive to concentration. The lighting and room temperature are items that need proper consideration. The disruptive influences of noise from outside the room can be a critical factor: especially if a recording of the proceedings is being made.

Finally, there are many benefits for the doctor who has good patient education programs. The physician has markedly enhanced his office efficiency. Better informed patients are more confident patients, thus reducing unnecessary phone calls and visits to the hospital emergency department. Group sessions help avoid constant repetitions from exam room to exam room, provide a time to allay patient anxieties and apprehensions, and reduce patient confusion over diagnosis and treatment programs. In addition, they give the doctor a greater patient exposure period which patients translate to increased care and concern about them. Patients appreciate the reduction in cost for an office visit when meeting in groups.

There is a sense of real accomplishment for a doctor actively involved in patient education programs in his office. He represents a stabilizing influence in an area where commercialism has reduced the patient to a gullible novice. Patients eagerly seek this type of physician and the medical community appreciates his dedication and efforts. He can be justly proud of his endeavors and their results.

Self-insurance saves you money, but it needs the care of a money manager.

Many hospitals have found significant savings in self-insuring their malpractice coverage. In fact, in-hospital coverage of workmen's compensation and other employee benefit programs such as dental, health, disability and group life insurance has dramatically increased the use of self-insurance in medical institutions.

Proper administration of a self-insurance program, however, needs the services of an experienced investment manager, Detroit Bank & Trust.

We've served Michigan residents for over 130 years and rank as one of the largest trust institutions in the midwest. Our outstanding record as a manager of fixed income securities and our extensive experience in administering employee benefit programs have led many hospitals to choose us as their investment manager for self-insurance plans.

If you would like more information on how we can help you with your self-insurance or employee benefit programs, call or write Terry Keating, Vice President, at (313) 222-3898, Detroit Bank & Trust, Box 59, Detroit, Michigan 48232.

Self-insurance is not your most important job, but managing your money better is ours.

DETROIT
BANK
& TRUST

Member FDIC

Principal Trust Offices in
Detroit • Birmingham • Gaylord

Mr. Terrence E. Keating, Vice President
Detroit Bank & Trust
Post Office Box 59
Detroit, MI 48232

Please contact us in regard to administering our self-insurance program.

Name____________________ Title________________

Hospital________________________________

Address________________________________

City________________ State________ Zip________

Telephone____________________

for his or her health — lose weight, stop smoking, etc. Further, the students learn to provide follow-up visits at which the patient can report on progress in altering detrimental habits.

In short, the MSU philosophy is that patients have to learn that doctors cannot do much to help them, unless they learn to help themselves.

At the U of M Medical School, Jane Schultz, MD, assistant dean for curriculum, says there is no particular health promotion course (although consideration is being given to an epidemiology elective), but that the concept is "insinuated into a lot of different courses."

Doctor Schultz says students have a tremendous overload of course work and the faculty wants to give them more time to think and to integrate what they are learning. "If anything helps health promotion," she adds, "that ought to do it."

At Wayne State University School of Medicine, Norval Scott, MD, of the Department of Educational Services and Resources has developed a prevention program for cancer and other diseases. Students start the program in their first year.

Wayne's Department of Family Medicine has been active in planning health promotion seminars. One was held last spring and another is scheduled for next year. Joseph Hess, MD, chairs the department.

What's behind it?

The boom in health promotion appears to stem from many factors. The one most commonly mentioned is that more and more patients are either quietly expecting it or noisily demanding it. Better educated and more exposed to medical information via the mass media, they want to know more about their health and what they can do to improve it.

Doctors, too, are changing, observers say. Younger physicians are often more health promotion-conscious than their predecessors; perhaps because of the way they were trained, perhaps because they are part of the same generation that expects promotion from doctors.

A health educator's view

Charles Kuntzleman, PhD, of Jackson, a health educator, stresses the point that people can frequently do more for their own health than the doctors can do for them. Physicians, he says, have to learn to tell their patients, "I can't do it for you. You have to do it yourself." And that message, he adds, has to be followed with explicit instructions as to what the patient should do.

Kuntzleman, who has a doctorate in exercise physiology from Temple University, is president of Fitness Finders, a consulting and multimedia production firm. Clients include the National Board of the YMCA and the Campbell Soup Co.

He was keynote speaker for the 1981 Health Promotion Conference Oct. 29 in East Lansing, sponsord by the Michigan Health Council.

Promotion of Michigan citizens' good health is one of the primary goals of the 40-year-old Health Council, which was founded in 1943 by MSMS.

The Kellogg Foundation now funds this major activity of the Health Council, which encourages cooperation among the state's diverse health associations, agencies and institutions to promote good health. The Health Council is working to develop new ways to offer advice and assistance, to offer ideas for projects and procedures, and to encourage networking.

The Health Council publishes a monthly newsletter, the "Good Health Advocate," which reports and ties together its activities to contribute in those three major areas. Among the Health Council's most recent major activities was coordination of 22 health fairs/screening programs in the Mid-Michigan area.

Although he is obviously an advocate of the health education programs he has produced, Doctor Kuntzleman emphasizes the need for physician involvement.

He says physicians are in an excellent position to teach patients self-responsibility and self-dependency. "They deal one-on-one with patients and can lay it on the line," Doctor Kuntzleman notes, adding that they can also appoint a staff member to provide information, understanding and emotional support for patients.

Doctor Urich also emphasizes the importance of physician involvement. Surveys show, he says, that "the physician is the most desired public source for public health and education."

"In addition, the physician is the only health professionial capable of interacting within the entire spectrum of health and disease."

ASIM has guide for establishing patient ed program

Seemingly countless studies have been conducted which demonstrate that educating patients saves on overall health care costs, increases patient compliance with treatment regimens and improves the physician-patient relationship. The results of these studies have been widely published, along with admonitions to physicians to spend more time educating their patients. There is little information, however, as to *how* to establish a reasonable and effective patient education program in medical practice.

Attempting to fill this practical information gap, the American Society of Internal Medicine (ASIM) has published "Patient Education in Practice," the sixth in a continuing series of eight-page practice guides which help physicians effectively manage the administrative side of medical practice. The new guide, divided into five sections, includes (1) the different groups of patients for whom patient education is important, (2) the "who, what, where, when and how" of patient education, (3) the different media available for educating patients, (4) a listing of various organizations offering patient education materials, and (5) a bibliography of information available on the subject.

The patient education guide is available by mailing $1 to ASIM at 2550 M St., NW, Suite 620, Washington, DC 20037. Bulk quantities (100 minimum) are available at a discount.

works well in your office...

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.

- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

ach gram contains: Aerosporin® (Polymyxin B Sulfate)
000 units, bacitracin zinc 400 units, neomycin sulfate
ng (equivalent to 3.5 mg neomycin base); special white
trolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz
pprox.) foil packets.

ARNING: Because of the potential hazard of nephro-
xicity and ototoxicity due to neomycin, care should be
ercised when using this product in treating extensive
urns, trophic ulceration and other extensive conditions
here absorption of neomycin is possible. In burns
here more than 20 percent of the body surface is
fected, especially if the patient has impaired renal
nction or is receiving other aminoglycoside anti-
otics concurrently, not more than one application a
ay is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Economic Recovery Tax Act has two important portions

By David R. Nadeau
Grand Rapids

In mid-August, Congress passed, and President Reagan signed, the Economic Recovery Tax Act of 1981. Among the many topics that are addressed in this Act, there are two items that should be of particular interest to members of the medical profession. These two items are the extension of Individual Retirement Accounts to all persons, regardless of their participation in an employer-sponsored plan, and the liberalization of the limits on contributions to a Keogh plan.

Beginning Jan. 1 the maximum contribution to an Individual Retirement Account will be increased from the present $1,500 to $2,000. In addition, the 15 percent of compensation limit has been eliminated. The limit for a spousal IRA has been increased from $1,750 to $2,250.

In addition, any individual who has been unable to establish an IRA because of his participation in an employer sponsored retirement plan, will be able to make tax deductible contributions to an IRA subject to the same new limitations mentioned above.

These individuals may make their contributions to their own IRA or may make tax deductible contributions on a voluntary basis to the retirement plan sponsored by the employer, *if* that plan permits those voluntary contributions.

Any amounts contributed under this provision will not be included in the annual additions in determining whether the maximum contribution has been made to a qualified plan or plans. If a physician's retirement plan is amended to permit deductible voluntary contributions, all employees must be given the opportunity to make voluntary contributions.

Before permitting these voluntary contributions, the sponsor of a plan should consider the following three items:

1. Annual earnings on these investments will be easily compared to those on IRA's available at a savings institution;

2. There could be additional administrative expenses involved in keeping tract of these contributions;

3. There may well be additional (as yet undefined) reporting requirements that could prove to be burdensome to the plan sponsor.

The second major area of the Act involving retirement plans is the increase of contribution limits for a Keogh plan. The annual limit on contributions has been increased to the lesser of 15 percent of earned income, or $15,000. In addition, the percentage of earned income on which the contribution may be based has been raised to $200,000, subject to the $15,000 limit. As in the past, however, if $200,000 of compensation is used, you must make contributions for common law employees at the rate of at least 7½ percent of their pay. While these limits do not approach the contributions limits permitted if the employer were incorporated, they do close the gap somewhat.

In addition, a change has been made in the ability of certain self-employed individuals to borrow from their individual accounts. Previously, self-employed individuals who owned less than 10 percent of the capital or profits of a business were permitted to borrow from their account. This Act, however, provides that a loan to *any* self-employed person from his account will be considered a taxable distribution. This provision will not affect any loans outstanding on Dec. 31, 1981.

There are two other provisions of the Act that may be of interest to plan sponsors.

The first is that Congress has extended the moratorium on the taxation of fringe benefits until Dec. 31, 1983. This will permit additional time for Congress and the public to present their viewpoints to the Treasury Department.

The second item deals with any Individual Retirement Account or any qualified plan which permits individually-directed investments. Specifically, the Act states that any acquisition of "collectables," such as works of art, precious metals, gems, or other such items shall be considered to be a distribution from the plan and subject to immediate taxation. This restriction applies only to those properties that are acquired after Dec. 31; therefore, such property which is currently held as an investment may remain in the plan withou being treated as a distribution. However, the question of whether displaying such an item in one's home or office is a prohibited transaction stil remains unanswered.

In the coming months, this column will deal with various aspects o retirement plans and retiremen planning. This will include a discussion of defined contribution plans defined benefit plans, distribution options under qualified plan, the role of the plan actuary and other topics which we feel will be of interest to members of the medical profession.

Mr. Nadeau is a senior consultant with Watkins, Ross, Baines, & Lamps Inc., an actuarial and employee benefit consulting firm with offices in Grand Rapids and Detroit. A Certified Employee Benefit Specialist and a member of the Midwest Pension Conference, Mr. Nadeau has over six years experience in the employee benefit area in both the government and private sectors.

PAIN AND TENSION...
Double fault for
weekend warriors
ACE THE ACHE
with

Equagesic®Ⓒ

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

***INDICATIONS**: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g , alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier It is present both in umbilical-cord blood at or near maternal plesma levels and in breast milk of lactating mothers at concentrations two to four times that of meternal plasma When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g , caffeine Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS. A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses, peripheral edema and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case) anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case) thrombocytopenic purpura agranulocytosis and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate 75 mg ethoheptazine citrate and 250 mg aspirin

Copyright © 1981, Wyeth Laboratories
All rights reserved

*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101

TM

Down with pain
Step up to reliable relief

for mild to moderate pain

Wygesic® Ⓘⓥ

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and, less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors, and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237 2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

Copyright © 1981, Wyeth Laboratories.
All rights reserved

Wyeth Laboratories
Philadelphia, PA 19101
TM

Does the new federalism mean more flexibility for the states?

By Dennis M. Paradis and Sherry N. Wellman
East Lansing

Editor's note: Gauging the impact of President Reagan's budget-cutting upon the practice of medicine in Michigan is not terribly easy yet. The details of exactly who and what programs will be affected are not clear. However, one of the best opportunities to get the first clues came at a recent AMA meeting described in the following article. Among the major topics of discussion at that meeting were the replacement of categorical programs with block grants, and the proposed greater flexibility for the states in Medicaid program administration. Health care analysts predict little actual change. They really expect to see the same health programs continue, with 75 percent or less of current funding. Please read on for the best information MSMS has to date on the impact of federal budget-cutting upon the practice of medicine in Michigan.

In September, the American Medical Association sponsored a conference in Chicago entitled, "Increased State Responsibility for Health Programs." Attending the meeting were Richard H. Gascoigne, MD, chairman of the MSMS Liaison Committee with the Michigan Department of Public Health; Jay K. Harness, MD, chairman of the MSMS Advisory Committee to the Bureau of Economics, and K. C. Das, MD, Muskegon. Dennis M. Paradis and Sherry N. Wellman of the MSMS staff also attended the conference.

Medicaid

A major portion of the conference was devoted to a discussion of state Medicaid programs and to the impact the Reagan Administration budget and programmatic proposal would have on those programs.

In the Medicaid area, the message was that the "new federalism" would mean a minimal role for the federal government with greater flexibility for the states.

Paul Willging, PhD, deputy administrator of the Health Care Financing Administration (HCFA), outlined new provisions designed to give the states more flexibility in the areas of reimbursement, eligibility, quality assurance and the delivery system.

In the area of reimbursement policies, Doctor Willging said that the greatest amount of change will be in Medicaid reimbursements to institutions, particularly hospitals. States will no longer have to reimburse hospitals at the Medicare rate. Instead, states will have flexibility to set reimbursement at levels they deem sufficient to cover the reasonable and adequate costs incurred by efficiently and economically operated hospitals.

For physicians, Doctor Willging noted that states will no longer be prohibited from making Medicaid payments for physician services which exceed Medicare levels. Given the low levels of Medicaid payments, this comment did not elicit a great deal of excitement from the audience, composed of physicians and medical society representatives from across the country.

It did not appear possible to those present that a Medicaid increase above Medicare levels would be likely. However, Doctor Willging pointed out that removal of the regulation could allow states to negotiate statewide fee schedules for physician services.

States will have more flexibility in determining eligibility for the medically needy under Medicaid. In the area of quality assurance, an important and controversial change will be removal of the requirement that state Medicaid agencies contract with PSROs. Under the new provisions, PSROs will be required to review health care services provided under Medicaid only if they are requested to do so by a state.

Delivery system changes will encourage states to use home health care and health maintenance organizations for Medicaid recipients. Doctor Willging emphasized that states will be given the opportunity to experiment through the new policy on waivers of freedom-of-choice and other state plan requirements. The

Continued on page 593

Mr. Paradis is Coordinator of Health Planning, MSMS Department of Government Relations, and Ms. Wellman is the Department's Coordinator for Public Policy and Political Affairs.

The impact of federal budget cuts on the Michigan Medicaid program was eloquently described to Michigan congressmen and their aides at a working session Sept. 16 in Washington, DC. Speaker of the MSMS House of Delegates and former Medicaid Liaison Committee Chairman David Siegel, MD, Lansing, did the talking.

Those listening to Doctor Siegel were gathered at the Rayburn House Office Building on the Hill. The session was part of a three-day visit to the capitol by MSMS officers and Michigan Doctors Political Action Committee board members. Also speaking at the working session were MSMS President James D. Fryfogle, MD; MSMS Legislative Policy Committee Chairman Charles L. Oppy, MD, and MSMS Legal Counsel A. Stewart Kerr.

In Williamston and Washington, MSMS members politically active

Photos by Joseph Berke, MD, and Thomas C. Payne, MD.

The Michigan congressional delegation attended the dinner marking the 20th anniversary of the American Medical Political Action Committee's founding. Enjoying conversation during the dinner at the Mayflower Hotel, Washington, DC, are, from left, Cecil Jonas, MD, Detroit; Joan Jonas, Detroit and B. David Wilson, MD, Kalamazoo.

Flanking former President Gerald R. Ford at a Republican fund-raising gala in Williamston in September are Michigan Doctors Political Action Committee chairman Thomas C. Payne, MD, and Cynthy Payne.

Secretary will be empowered to waive certain requirements when they are not inconsistent with the purposes of Medicaid. Waiver of the freedom-of-choice requirement, for example, would allow a state to implement a case-management or a specialty physician services arrangement that will restrict the recipient to a single provider of primary care services. States also may arrange for the purchase of laboratory services and medical devices through a competitive bidding process.

Although the final regulations have not been written, Doctor Willging predicted that they would not run counter to the philosophy of the new federalism and flexibility for state administration of Medicaid programs. In fact, he commented that it was his belief that if an experimental proposal is not explicity prohibited by the statute, a waiver would be granted automatically.

Paul M. Allen, director of the Medical Services Administration within the Michigan Department of Social Services, shared the platform with Doctor Willging. Mr. Allen also serves as chairman of the National Association of Medicaid Directors and views the new federalism for Medicaid from both a state and national perspective. He described the State of Michigan and its Medicaid program as a microcosm of the problems and solutions other states are just beginning to face. Eleven percent of Michigan's population is eligible for Medicaid, and Medicaid accounts for 13 percent of the state's budget, he pointed out. Mr. Allen commented that Michigan is a relatively affluent state in the sense that personal income is higher than average. However, the high unemployment rate in Michigan has resulted in an income disparity that means an individual "either makes $20,000 a year or is on Medicaid," he said.

Mr. Allen is more skeptical than Doctor Willging on the potential results of the increased flexibility for state Medicaid programs. He noted that Michigan has tried many innovative experiments, and while savings have been realized, they have not kept pace with increased costs of providing Medicaid services. He cited Michigan's second surgical opinion program, the prospective hospital rate reimbursement system, the lower-than-average nursing home rate, extensive use of HMOs, the recipient monitoring program and the state's debedding program.

Mr. Allen commented that he expected many states to follow Michigan's example and implement similar programs. He noted that the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons have proposed a plan to lock-in Medicaid eligibles with primary sponsors which will be tried on a pilot basis beginning in 1982.

Mr. Allen concluded by saying that Michigan, for one state, is ready to conduct further experiments with Medicaid in the hope of cost savings. But he questioned whether there actually are a significant number of innovative ideas that Michigan has not already tried.

Block grants

In the past years, the federal government has enticed the states to initiate public health programs by making federal funds available in tightly prescribed categorical grants. The Reagan administration proposed that these categorical grants be replaced by block grants. Congress since has made substantial modifications in the original concept.

The original concept behind block grants was to amalgamate approximately 30 categorical programs in two block grants. The purpose was to reduce the bureaucracy necessary to administer the many categorical programs and to give the states greater flexibility in using the funds for state priorities.

The end result of Congressional deliberation was to leave as is seven categorical programs **(family planning, childhood immunization, venereal disease, tuberculosis, migrant health care, developmental disabilities and adolescent family life)** and consolidate 24 other health programs into four "block" grants as follows:

Preventive health: (Emergency Medical Services, Health Incentive Grants, Hypertension Control, Rodent Control, Fluoridation, Health Education/Risk Reduction, Home Health Services, Rape Prevention and Crisis Services).

Maternal and Child Health Services: (Maternal and Child Health Services/Crippled Children's Services, SSI Disabled Children's Services, Hemophilia, Sudden Infant Death Syndrome, Lead-Based Paint Poisoning Prevention, Genetic Diseases, Adolescent Health Services).

Alcohol, Drug Abuse and Mental Health: (Mental Health Services, Drug Abuse Project Grants, Drug Abuse State Formula Grants, Alcoholism Project Grants, Alcoholism State Formula Grants).

Primary Care: (Community Health Centers, Primary Care Research and Demonstrations).

Citing the anticipated decreased administrative demands on the states which will result, Congress cut the authorization for these block grants 25 percent from the combined funding level of the categorical grants. The actual appropriations may be lower yet. The greatest disappointment to public and private health care providers, however, is not the decreased funding levels, but the lack of flexibility available to the states in using these funds.

The promise that made block grants alluring was increased flexibility to use the federal monies for state priorities. However, when Congress passed the block grants, they included provisions that sharply curtailed the ability of the states to use the money for other than federally determined purposes.

For example, funds from the maternal and child health services and the primary care block grants cannot be transferred to other areas. Only seven percent of the other two blocks can be transferred. Even more restrictive are the "maintenance of effort" clauses in each of the block grants. These clauses require that some of the categorical program efforts be continued at specified funding levels. Budget analysts speculate that after the maintenance of effort requirements are met, there will be little money left to meet state priorities.

The reality of the block grant program is sharply decreased federal program dollars with little state level discretion on how they are to be spent. In Michigan it is assumed that federal programing will continue in much the same pattern as in the past, but with fewer dollars. It is hoped that the promised state flexibility will follow in the future fiscal years.

MSMS reports on legislation affecting medicine in Michigan

By Ellen Vinocur Potash
East Lansing

Now that the legislature has returned to Lansing, the lawmakers are placing great emphasis on the Governor's proposals to strengthen the economic climate in Michigan.

However, the economy is not the only area which will receive attention during this legislative session. Health-related legislation will figure prominently in the legislative action.

Of particular interest are:

HB 4867
Physician Ownership In Clinical Laboratories

HB 4867, introduced by Rep. Raymond Hood and referred to the House Committee on Public Health, would prohibit a physician from referring laboratory work to any lab facility in which he/she had any financial interest. Financial interest is defined as: "a direct or indirect interest in a general partnership, corporation, professional corporation, joint venture, or other business other than any of the following: (a) ownership of stock of a public corporation; (b) physician's own practice when services are prescribed by the physician for his/her own patients; (c) an interest in property resulting in a landlord-tenant relationship providing that the rent is not determined, in whole or in any part, by the business volume or profitability of the tenant or is otherwise unrelated to a reasonable market value; (d) an HMO.

In July 1980, The Council of MSMS adopted the recommendation of its Legislative Policy Committee regarding physician-owned referral services. It was recommended that MSMS support the policy that physicians should have the privilege of owning a financial interest in referral services and facilities, but that when physicians refer patients to such services and facilities, the patient should be informed of such ownership. This recommendation stands in direct contrast to the language found in HB 4867. *Therefore, it is anticipated that MSMS will vigorously seek to change the legislation to reflect the MSMS policy statement.*

Ms. Vinocur Potash is Assistant for Public Policy, MSMS Department of Government Relations.

HB 4945 (same as SB 398)
Transportation of Radioactive Materials in Michigan

HB 4945, introduced by Representative Lynn Jondahl and referred to the House Committee on Public Health, establishes that the Department of Public Health shall license and regulate transportation of radioactive materials in Michigan. A concern for hospital radiology is Section 13551 of the bill which reads:

> "(1) A person transporting radioactive material in or through this state shall cause escort vehicles to precede and follow the vehicle transporting the radioactive materials. Each escort vehicle shall carry constantly functioning equipment capable of detecting any release of radioactivity from the shipment."

Hospital and laboratory radiologists indicate that such precautions are hardly necessary for the transportation of radiopharmaceuticals and that the cost of the safety measures prescribed in Section 13551 would be wasted expenditures for the transporters of said materials. These costs would be passed on to the radiology departments and ultimately to the consumers.

The federal Department of Transportation has published a final rule pertaining to radiopharmaceutical transportation which states that "the public risks in transporting these materials by highway are too low to justify the unilateral imposition by local governments of bans and other severe restrictions on the highway mode of transportation. *It is expected that MSMS will actively seek to exempt radiopharmaceuticals from the requirements of this legislation.*

HB 4710
Pituitary Gland Retrieval

This legislation which was introduced by Reps. Collins, R. Hood, and Kilpatrick, has passed the House of Representatives and is currently in the Senate Committee on Public Health awaiting committee action. HB 4710 would amend the Public Health Code so that a physician, including a medical examiner, performing an autopsy, post-mortem, or dissection could remove and retain the pituitary gland of the deceased provided certain conditions had been met. The conditions are: (1) consent for removal and retention has been obtained; (2) the physician is unaware of a prior objection by the deceased before death or by next of kin after death; (3) the removal and retention of the pituitary gland of the deceased is to be performed for purposes of medical research, education or therapy.

The removed pituitary glands could be submitted to hospitals, medical education or research institu-

Continued on page 596

In business communications it takes teamwork to get the job done right!

Effective business communications calls for a tightly knit team that knows communications, knows your business, and knows the importance of reaching your goals as planned and on time. At Michigan Bell we collectively call these specialists the Bell Team. There are many of them . . . each headed by an Account Executive calling the shots, experts in telephone communications and data transmission as well. And equally important, Michigan Bell Account Executives are trained and experienced in the effective application of communications equipment and systems in specific fields: insurance, automotive, banking and many others.

But no Account Executive goes it alone. He or she is backed by a team . . . a staff of industry specialists in the many communications areas . . . who can skillfully execute your plans. So why settle for less when you can call on the skills of the whole team? The Bell Team . . . people who know their business and your business.

Michigan Bell

New legislation of medical interest is introduced regularly. Watch *Medigram* and future issues of *Michigan Medicine* for periodic updates.

tions, or to individuals or organizations for the purpose of treating another human being. Except for a reasonable charge related to the actual costs of removing the pituitary gland, the removed pituitary gland must be submitted without charge. The hospital, medical education or research institution, or other individual or organization receiving the gland shall agree to furnish the gland, or a hormone produced from the gland to individuals without charge. *This legislation was sought by and strongly supported by The Michigan State Medical Society.*

Bills enacted

Before the July 1 recess of the legislature, the following bills were passed:

Prepare For:

- TOEFL
- MSKP
- NATIONAL MEDICAL BDS
- VQE
- ECFMG
- FLEX
- DENTAL BDS
- PODIATRY BDS
- NURSING BDS

- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.
- Over 40 years of experience and success in the field of test preparation.

Stanley H. KAPLAN EDUCATIONAL CENTER

For Information Please Write or Call:
Crossroads Office Centre
16250 Northland Drive
Southfield, MI 48075
(313) 569-5320
Centers in More Than 80 Major US Cities, Puerto Rico, Toronto, Canada & Zurich, Switzerland.

PA 79 of 1981
Emergency Medical Services (EMS)

(Introduced as SB 159 by Senator Edward Pierce)

MSMS was instrumental in drafting and supporting this legislation pursuant to a mandate from the 1980 MSMS House of Delegates. PA 79 used physician expertise to fine-tune the existing emergency medical services legislation which has been held up as a national model. The 15-month effort to seek passage of the legislation culminated with Governor Milliken's signature on June 30, six hours before the existing legislation was scheduled to expire.

PA 76 of 1981
Fees for Health Facilities Licenses

(Introduced as HB 4620 by Representative Joyce Symons)

Public Act 76 establishes a licensure fee schedule for freestanding surgical outpatient facilities, hospitals, nursing homes, county medical care facilities, hospital long-term care units, homes for the aged, health maintenance organizations, clinical laboratories and certificates of need. Previously, the law required the Department of Public Health to establish fees annually. Public Act 76 makes the current fees the established fees for the future with the proviso that not more than one-half the annual cost of licensure activities as determined by the Department shall be provided by license fees. In other words, the maximum licensure and certificate of need fees are established by law.

PA 117 of 1981
Mandatory Child Restraint

(Introduced as SB 115 by Senator George Hart)

Public Act 117 amends the Michigan Motor Vehicle Code to require drivers to properly secure passengers under the age of one in child seating systems which meet federal standards and children between the ages of one and four either in one of these systems or with a safety belt in the rear seat. The secretary of state can exempt children for whom the use of the required child seating system is impractical because of physical unfitness, medical problems, or body size, and specify alternative means of protection for these children.

The bill was amended in the House to reduce the maximum allowable fine for violation of the bill from $25 to $10. The court will waive the civil fine or cost if the violator supplies the court with evidence of the acquisition, rental, or purchase of a federally-approved child seating system prior to the appearance date of the citation. *The 1981 MSMS House of Delegates passed a resolution supporting mandatory child restraints for children between the ages of one and four.*

PA 121 of 1981
Hospital Capacity Reduction Corporation

(Introduced as HB 4332 by Representative William Ryan)

The Hospital Capacity Reduction Corporation is designed to assist in hospital closure by authorizing necessary funding. *MSMS worked to limit the role of the HCRC to hospitals identified by hospital bed reduction plans.*

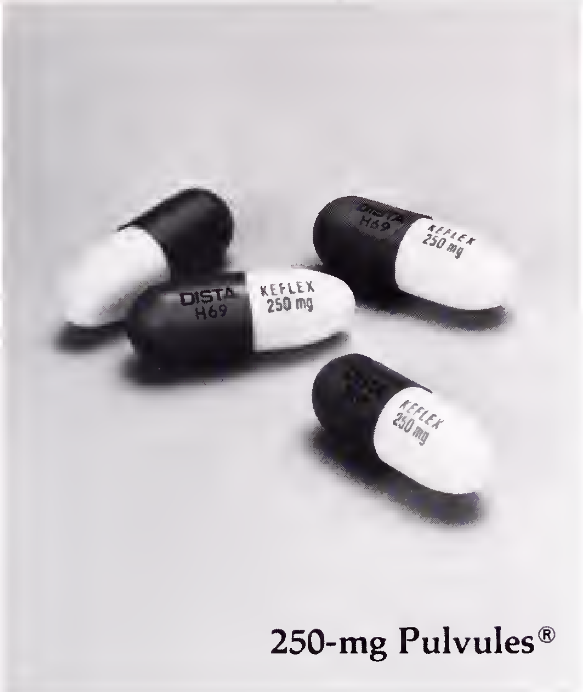
This publication is available in microform.

University Microfilms International

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London W1N 7RA
England

easy to take



250-mg Pulvules®

Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes

Pediatric Drops

100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Sen. Sederburg influential member of Senate Health and Social Services Committee

By Willah Weddon
Stockbridge

Sen. Sederberg

"I've been surprised how many hot political issues are related to the health profession," State Senator William A. Sederburg says. "Having a background in education, that came as a surprise to me."

The 34 year-old Senator, with a PhD in political science and public administration, taught public administration courses at his alma mater, Michigan State University, from 1973 to 1975. During these two years he also served as a member and secretary of the State Board of Education.

Although he subsequently served as an Ingham County Commissioner, chairman of the Ingham County Republican party and as director of the House of Representative's Republican staff, he still considers educational financing "my number one priority in the legislature."

Elected in 1978 to the Senate from his home district, composed of the north portion of Ingham County (24th), Sen. Sederburg was named to serve on the Senate Health and Social Services Committee. (He is also a member of the Education Committee and the Environmental Affairs Committee.)

"I had a general interest in human services," he explains of his appointment to the Health committee. "I didn't have a specific agenda on public health issues." He has served, however, on the Board of Trustees of the Michigan Lung Association and the Michigan Multiple Sclerosis Society.

As for the role of lawmakers in medical legislation, Sederburg is explicit. "Ideally the legislature ought to be less involved with the health care system, because that would indicate the public was well satisfied and the system working well," he said. "We get involved when there are complaints or problems."

"But once an issue emerges, then I think the legislators ought to become more informed as to how the health care system works," he continued.

During the current session, Sederburg anticipates the Health and Social Services Committee will deal with three main issues: the State Health Plan, HMO legislation and lessening regulation of nursing homes and homes for the mentally retarded.

He expects State Health Plan controversy will concern targets for hospital bed utilization, the number of physicians in the state and mental health services.

"We're going to have to coordinate with federal regulations whe we rewrite the HMO legislation," h pointed out. "We're also going t have to consider the block grant program (which took effect in October) As the federal program funding i changed, we'll have to change ou state system. I don't know what th effect will be."

Regarding regulations of nursin homes and homes for the mentall retarded, Sederburg believes the may reduce regulations similar to th way they have reduced them for hospitals, calling for an inspection onl every two years.

He predicts the nursing hom bill (SB 173) which would eliminat a certificate of need from the Michigan Department of Public Health before planning a change in bed capacity or in service, "isn't going to g anywhere."

Direct and to the point, Sederburg has a lot of brain power goin for him. (He was a national officer o Kappa Delta Pi, an education hono society, for two years.) He has a reputation for getting things done, i other districts as well as in his own But when asked if he might join th circle of senators making a bid for th governorship he replied quickly with a chuckle. "That's an easy on to answer. I do not plan to run fo Governor."

Nevertheless, political pundit are confident Sederburg will have leadership position if the Republicans win dominance in the 1982 senate election.

How does he like being senator? "It's like any other job Some days you like it and some day it's not so much fun," he said. "Yo have to be a certain type of person t enjoy it. I enjoy it."

Ms. Weddon is a Lansing area freelance writer.

n Hypertension...When You Need to Conserve K$^-$

Every Step of the Way

DYAZIDE®
ADD OR SUBSTITUTE GUANETHIDINE
DYAZIDE®
ADD VASODILATOR
DYAZIDE®
ADD BETA-BLOCKER, CNS INHIBITOR OR RESERPINE
DYAZIDE®
EFFECTIVE STEP 1 DIURETIC THERAPY† (when the combination represents previously titrated dosage)

ach capsule
ontains 50 mg. of
yrenium® (brand of triamterene)
nd 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K$^+$ supplement or K$^+$-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K$^+$ supplement or K$^+$-sparing agent).

Serum K$^+$ and BUN should be checked periodically (see Warnings).

efore prescribing, see complete prescribing information SK&F Co. literature or *PDR*. The following is a brief mmary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

ntraindications: Further use in anuria, progressive renal hepatic dysfunction, hyperkalemia. Pre-existing elevated rum potassium. Hypersensitivity to either component or her sulfonamide-derived drugs.

arnings: **Do not use potassium supplements, dietary or herwise, unless hypokalemia develops or dietary intake potassium is markedly impaired**. If supplementary potasum is needed, potassium tablets should not be used. Hyperlemia can occur, and has been associated with cardiac egularities. It is more likely in the severely ill, with urine lume less than one liter/day, the elderly and diabetics with spected or confirmed renal insufficiency. Periodically, rum K$^+$ levels should be determined. If hyperkalemia velops, substitute a thiazide alone, restrict K$^+$ intake. **Assoated widened QRS complex or arrhythmia requires ompt additional therapy**. Thiazides cross the placental rrier and appear in cord blood. Use in pregnancy quires weighing anticipated benefits against possible hazds, including fetal or neonatal jaundice, thrombocytopenia, her adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K$^+$ frequently, both can cause K$^+$ retention and elevated serum K$^+$. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established.

Supplied: **Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

SK&F CO.
a SmithKline company
Carolina, P.R. 00630

The
25%
solution
A dozen inexpensive ways to cut energy use by as much as 25%.

Gregory Peck offers you 12 ways to save energy.

This free brochure and a walk through your house could cut your home energy use by 25%.

For example, the brochure tells you to insulate the gaps you left the first time around. Look for them.

It tells you to lower your water temperature to 120 degrees. Check it.

It tells you 10 other proven money-savers. Follow them.

Best of all, it tells you that saving energy makes sense. Dollars and cents.

Mail the coupon to the Alliance to Save Energy today.

THE ALLIANCE TO SAVE ENERGY

Box 57200, Washington, D.C. 20037

Please send me your energy-saving, money-saving brochure

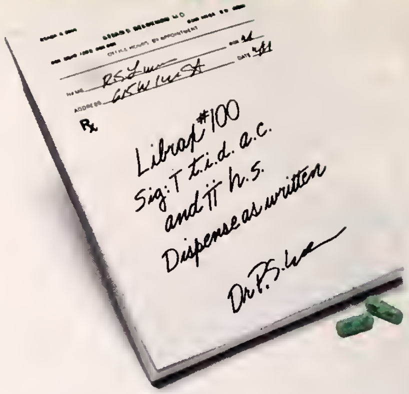
NAME ____________________

ADDRESS ____________________

CITY __________ *STATE* ____ *ZIP* ______

Ad Council *A public service message from this magazine and the Advertising Council*

Specify
Librax®


Librax #100
Sig: T t.i.d. a.c.
and ṫṫ h.s.
Dispense as written
Dr P.S.

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving) Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

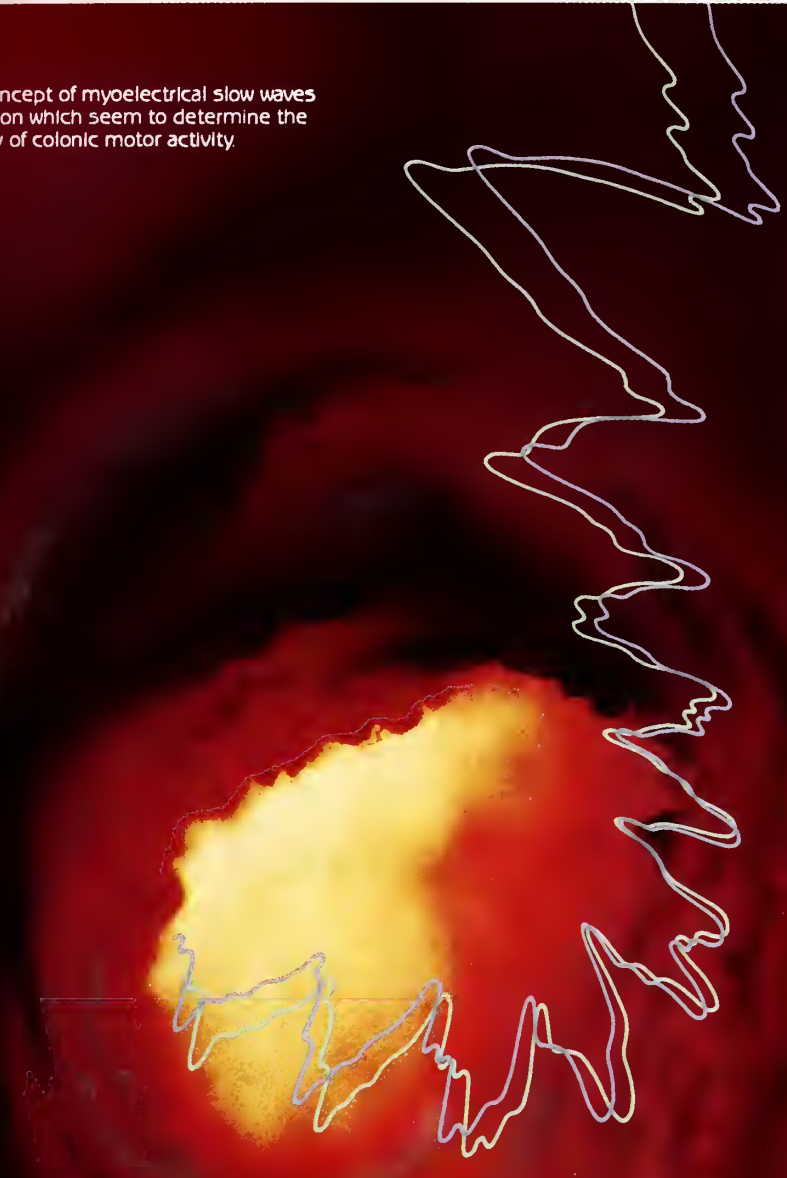
As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated) Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges Syncope reported in a few instances Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy Adverse effects reported with Librax typical of anticholinergic agents, *i e*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

Irritable BOWEL SYNDROME*



rtist's concept of myoelectrical slow waves
f the colon which seem to determine the
equency of colonic motor activity.

A visible difference in myoelectric rhythms of the colon

Studies reveal an increased frequency of 3-cycles-per-minute slow wave basic electrical activity in the colons of patients with IBS—a significant difference in basic colonic rhythm patterns from normal subjects.[1,2] These findings suggest a physiological basis for the spasm and hypermotility characteristic of IBS. The role of severe anxiety in triggering or aggravating such symptoms has long been recognized. Consequently, treatment should focus on both aspects of the problem.

Librax: A logical choice for patients with IBS

Logical, because the antimotility-antispasmodic actions of the Quarzan®(clidinium bromide/Roche) component of Librax can help to relieve the distressing abdominal symptoms associated with IBS.* Logical, because the antianxiety actions of the Librium® (chlordiazepoxide HCl/Roche) component can help to reduce the excessive anxiety that can contribute to IBS flare-ups.

References: 1. Sullivan MA, Cohen S, Snape WJ. *N Engl J Med 298:*878-883, Apr 20, 1978.
2. Snape WJ *et al: Gastroenterology 72:* 383-387, Mar 1977.

Specify Adjunctive **Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

ROCHE®

*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.

for Knotts in the night
Prescribe new formula
Quinamm*
(quinine sulfate tablets)
each tablet contains quinine sulfate 260 mg

Specific therapy for painful night leg cramps

Merrell Dow

*Trademark of MERRELL-NATIONAL LABORATORIES Inc.,
Cayey, Puerto Rico 00633

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease . . . consider Quinamm . . . simple, convenient dosage—usually just one tablet at bedtime . . . can provide restful, welcome sleep without night leg cramps.

Quinamm™
(quinine sulfate tablets)

CAUTION Federal law prohibits dispensing without prescription
BRIEF SUMMARY

INDICATIONS AND USAGE

For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS

Quinamm may cause fetal harm when administered to a pregnant woman Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g) for attempted abortion In about half of these reports the malformation was deafness related to auditory nerve hypoplasia Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys Quinamm is contraindicated in women who are or may become pregnant If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use Recovery usually occurs following withdrawal of the medication and appropriate therapy

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever

WARNINGS

Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision, however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine Quinamm should be stopped immediately if evidence of hemolysis appears

If symptoms occur, drug should be discontinued and supportive measures instituted In case of overdosage, see OVERDOSAGE section of prescribing information

PRECAUTIONS

General

Quinamm should be discontinued if there is any evidence of hypersensitivity (See CONTRAINDICATIONS) Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine (See Drug Interactions)

Drug Interactions

Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

The effects of neuromuscular blocking agents (particularly pancuronium succinylcholine and tubocurarine) may be potentiated with quinine and result in respiratory difficulties

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity

Drug Laboratory Interactions

Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used

Carcinogenesis, Mutagenesis, Impairment of Fertility

A study of quinine sulfate administered in drinking water (0 1%) to rats for periods up to 20 months showed no evidence of neoplastic changes

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test Intraperitoneal injections (0 5 mM kg) were given twice, 24 hours apart Direct *Salmonella typhimurium* tests were negative, when mammalian liver hemogenate was added, positive results were found

No information relating to the effect of quinine upon fertility in animal or in man has been found

Pregnancy

Category X See CONTRAINDICATIONS

Nonteratogenic Effects

Because quinine crosses the placenta in humans the potential for fetal effects is present Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown Quinine in toxic amounts has been associated with abortion Whether this action is always due to direct effect on the uterus is questionable

Nursing Mothers

Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts)

ADVERSE REACTIONS

The following adverse reactions have been reported with Quinamm in therapeuti or excessive dosage (Individual or multiple symptoms may represent cinchonism or hypersensitivity)

Hematologic acute hemolysis, thrombocytopenic purpura agranulocytosis hypoprothrombinemia

CNS visual disturbances, including blurred vision with scotomata photophobia diplopia, diminished visual fields and disturbed color vision tinnitus deafness and vertigo, headache nausea vomiting fever, apprehension restlessness confusion, and syncope

Dermatologic allergic cutaneous rashes (urticarial the most frequent type o allergic reaction, papular, or scarlatinal), pruritus, flushing of the skin swealing occasional edema of the face

Respiratory asthmatic symptoms

Cardiovascular anginal symptoms

Gastrointestinal nausea and vomiting (may be CNS-related) epigastric pain

DRUG ABUSE AND DEPENDENCE

Tolerance abuse or dependence with Quinamm has not been reported

OVERDOSAGE

See prescribing information for a discussion on symptoms and treatment o overdose

DOSAGE AND ADMINISTRATION

1 tablet upon retiring If needed, 2 tablets may be taken nightly—1 following th evening meal and 1 upon retiring

After several consecutive nights in which recumbency leg cramps do not occu Quinamm may be discontinued in order to determine whether continued therap is needed

Product Information as of October, 1980

Licensor of Merrell*

MERRELL-NATIONAL LABORATORIES Inc
Cayey Puerto Rico 00633

Direct Medical Inquiries to

Merrell

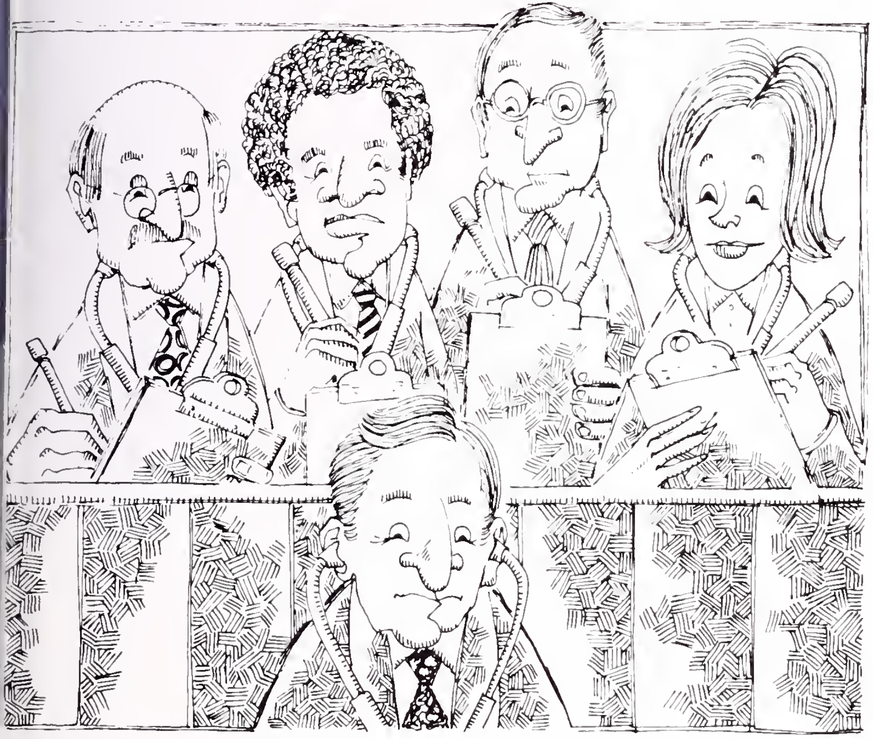
DOW

MERRELL DOW PHARMACEUTICALS INC
Subsidiary of The Dow Chemical Compan
Cincinnati, OH 45215, U.S.A

1-8137 (Y437C)MNQ-699

Hospital Performance Measurements Study shows wide variety in hospital use, costs

By Martha Climo
East Lansing



Enormous differences exist among apparently similar Michigan cities with regard to the costs and use of medical care delivered there. Large cities tend to have higher rates of both use and cost of health care.

Those are among the most signifcant preliminary findings of the Hospital Performance Measurements study being conducted by a team of researchers from Boston University and the University of Michigan.

However, when they tested for such factors as income, the impact of age and the percentage of Blue Cross coverage, the researchers did not clearly uncover any factors to explain the differences. They continue to work to solve that mystery.

Ms. Climo is a free-lance writer.

The study is supported by the Kellogg Foundation and the Michigan Hospital Association. MSMS is a member of the consortium which compiles the data, the Michigan Health Data Corporation.

MSMS representative on the corporation board is Daniel J. Fall, MD, Ann Arbor. Other physicians helped develop the quality of measures for the study, in conjunction with the University of Michigan. The MSMS Bureau of Economics provided staff support to Doctor Fall and served on technical committees.

John Griffith, PhD, professor and director, Department of Hospital Administration, the U-M, heads the research team. The team's purpose is to provide information to hospital trustees, executives and medical staffs around the state so that they can evaluate their services and plan changes to make them more efficient.

Some communities low

"While revealing that there is a large variation in the use of hospital care among Michigan communities," Griffith said, "the study also demonstrates that at the low end of the scale, some Michigan communities operate at levels nearly competitive with health maintenance organizations.

"Most Michigan communities have patient day use rates below the state mean. This suggests that larger cities tend to have higher use rates," he said. Furthermore, hospital insurance costs are twice as high for some communities as for others.

Griffith said that high costs of hospital care in some communities generate high employment in the hospital industry. A peremptory shift downward in use and cost of hospital care in those communities might generate unemployment. He explained that it would be disruptive of medical staff relations and might cause some patient dissatisfaction.

"Whatever the communities decide to do," he said, "they would not want to move suddenly or precipitously. Rather, they would want to plan their moves carefully and strive for long-range shifts."

Griffith said that good management, concurrent utilization review, physician and patient education and the provision of better ambulatory care all are likely to reduce unnecessary admission and patient days. To make those improvements, it will be necessary to change annual budgets, the supply and location of facilities and the number and kind of physicians recruited.

The findings provide a rich opportunity for further analysis. The project will undertake studies of specialized populations: in particular, the Medicare age group and the portions of the population insured by Medicaid and Blue Cross. The study will examine a number of demographic variables to determine their impact upon the major measures.

The project is working to analyze:

- Where people get their hospital care, so that service communities for hospitals or groups of hospitals can be identified;
- How much care they get, so that communities can consider how they compare to others;
- What the insurance costs of that care are; and
- Some indicators of quality through identification of some community health problems that the hospitals might attack or help others attack.

To do the study, the researchers used discharge abstracts from Michigan hospitals. They divided the state into hospital use communities with measured populations and constructed population-based rates measuring use, cost and selected aspects of quality.

The first of a number of articles from the study was published this past summer. The article presents the first comprehensive report on Community Hospital Services for a major industrial state. The results are based on data from the first six months of 1978 from 54 Michigan communities, with a total population of 8,000,000 persons, or 90 percent of Michigan's lower peninsula population. The communities include Detroit and several adjacent suburban areas, all other places with populations over 100,000 (except Lansing) and 27 smaller rural communities in the lower peninsula. The study reveals wide diversity within regions of the state and a tendency for large cities to have higher rates both of use and of cost.

The report revealed that "for decades, community hospital decision makers operated in an environment of seemingly unlimited financial support and apparent public enthusiasm for expansion and modernization. In recent years, however, concern has developed over the effects of this growth, particularly with regard to costs and the increasing burden on taxpayers. Containing costs is by no means a simple matter, for serious questions arise regarding access, quality and employee compensation. The planning and operating environment has changed dramatically, necessitating reconsideration of hospital goals as well as mechanisms for evaluating hospital performance."

"To meet these changing responsibilities, hospital decision-makers require information on such fundamental matters as the nature of the community they serve, how much the care costs and the quality of the care."

In a recent review of the work, Robert Sigmond, Advisor on Hospital Affairs, Blue Cross/Blue Shield Associations, Chicago, explained that most hospitals have had great difficulty in relating their planning processes to a population base, as contrasted with a patient base. For one thing, many hospitals have found it virtually impossible to get relevant data on the health service patterns or their service area populations for use in planning changes in their programs.

"Without this information, evaluation has been the weakest link in the planning processess of most hospitals. These planning processes have tended to focus almost exclusively on institutional requirements, as contrasted with the requirements of the hospitals' service area, populations."

Sigmond said that the importance for hospital planning of the initial publication of the Hospital Performance Measurement Study is that it shows that population-based evaluation data can be assembled on individual hospitals and on 'hospital cluster' bases from readily available sources, and that early discussions with local communities already have begun.

Information shared

So far, the researchers have held several meetings with trustees and medical staff of many of the hospitals and have returned several times for additional discussions. Early participation was more promising than expected.

The presentations were made in two stages: first to administrators only and later to administrators, trustees and medical staff representatives. Physicians were particularly concerned with methodological issues but, thus far, have accepted the project and in some cases inquired about further presentations to their colleagues, says Doctor Griffith. Some cities and hospitals have expressed interest in improving or maintaining their relative status and have already begun to incorporate the new information into planning.

More scientific papers are in progress. Also, a hospital planning data source book will be on sale for hospitals which will include graphic and tabular displays of communities and hospitals in the Michigan study.

"Overall, the goal is to make the information as useful as possible to people," Doctor Griffith says. "We are trying to improve the work of trustees, hospital administrators and doctors in terms of cost and community welfare."

Already, other states are interested in the research and are trying to undertake similar studies.

Implications

Doctor Griffith says that, today, communities are trapped by the relative rise of health care costs and the steadily aging populations. Communities' dilemmas won't be made any easier by the increasing number of physicians in the near future. Although many Michigan communities have learned to sustain their populations with modest quantities of hospital care, others have not, he says. Communities which still need to learn will benefit most from the study.

According to Jay Harness, MD, chairman of the Advisory Board to the MSMS Bureau of Economics, "With the pressure we are under to reduce costs, length of stay and admission to hospitals, we need to understand the data from the Hospital Performance Measurements study. We need to understand why the differences in hospital costs and effectiveness exist in seemingly similar locations throughout the state.

"I hope that Doctor Griffith will continue to share this data with hospital staff throughout the state."

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN

Healthy Competition
Makes A Healthier Market

Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.

Occurrence Coverage

Choice of limits—$100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

MSMS Council hears new public health director

By Bailus Walker, Jr., PhD, MPH
Lansing

Doctor Walker

The following article is taken from Doctor Walker's remarks to the MSMS Council, Sept. 9 in Lansing. Doctor Walker appeared before the councilors at their invitation.

It would be grossly deceitful of me to attempt to conceal the pleasure and sense of pride that this meeting brings to me.

Aside from the historical influences, the continuing importance of the Michigan State Medical Society to the whole public health movement points up the necessity for good communications between the medical profession and the Michigan Department of Public Health (MDPH).

To be sure, many of the programs sponsored by MDPH require the active cooperation and participation of private physicians.

Doctor Walker is director of the Michigan Department of Public Health.

It has been said that every private physician should be, in effect, a deputy health officer; and the private office should represent the individuals and families served as a branch of the health department.

In fact, I want to commend those thousands of physicians who emphasize preventive, promotive, as well as therapeutic medicine in their daily contact with individuals and families of this State.

Private medical practice and public health activities affect each other considerably. Modern public health programs depend greatly on concurrent effective private practice; and every public health worker knows that the science and art of medicine are two of the foundations of public health.

In turn, many public health activities such as occupational and environmental health services, laboratories and health education support the work of private physicians.

We recognize that in the broad societal attack on disease problems, three main avenues of advance are now open: (1) *occupational and environmental health measures*, (2) *health education*, and (3) *personal health care*.

The parts of this triumvirate are complementary.

Personal health care embraces all those services to individuals that are performed on a one-to-one basis by health care professionals.

Much of the personal health services are given directly by members of the medical profession and most of the rest are given by others under the direction of physicians.

The potential of medical care for overcoming disease and disability may be illustrated by (1) success achieved with vaccination and immunization, (2) advances in surgical knowledge, (3) successful application of improvement in diagnosis to the reduction of cervical cancer, and (4) with increased appreciation of the immunological hazards to be encountered and controlled, the practical reality of organ transplantation, particularly of the kidney. If transplantation is impossible or delayed, hemodialysis offers an efficient method of ridding the blood of waste and thus prolongs the life of many who otherwise would have died of renal failure.

In my view, the effective state health department recognizes the contributions of the professional associations such as the Michigan State Medical Society, and profits from good relations with them. Thus, new programs and proposals which affect you will be discussed in advance with appropriate committees of the Society.

It is clear to me that the Michigan Department of Public Health has had a close and cooperative relationship with MSMS.

My predecessor, Maurice Reizen, MD, was awarded the Society's Presidential Citation earlier this year, and I have just read the August issue of your official journal, *Michigan Medicine*, in which Kenneth Wilcox, MD, chief of our Bureau of Disease Control and Laboratory Services, was a prominent "feature".

The State Health Department's work with your Maternal and Perinatal Health Committee, your Public Health Committee and the Task Force on Maternal-Fetal Medicine are but a few examples of the outstanding relationship between MDPH and MSMS.

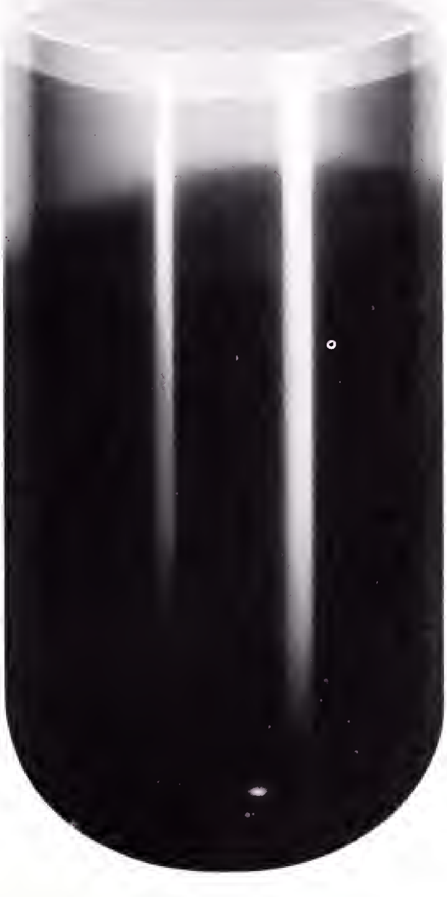
These relationships must and *shall* continue, and even improve, as we carry out our joint responsibility to the people of this state.

Over the years that I have worked in organized public health, my own mutually productive relationships with the Ohio State Medical Society, the Cuyohoga (Ohio) County Medical Society, the Minnesota State Medical Society, and the

Continued on page 60

Put us to the test.

Send us a split specimen—at our expense—we'll prove our accuracy.



First, establish an account with us. It won't cost you anything. Then at your convenience, draw a specimen using accepted procedures. Divide it and submit it under two names. When you receive the results, and you're satisfied they're statistically parallel, call us. We'll credit your account. It's that simple.

What else can you expect?

Quick results. We have three strategically located labs to provide routine test results within 24 hours, tissue results within 48 hours. Plus STAT service on some procedures.

Pickup and mail service. In many areas, our trained couriers will pick up your specimens. Outside our wide service areas, we provide prepaid mailing containers.

Quick-scan highlighted reports. Our reports were designed by pathologists. Abnormals are highlighted, making them easy to spot.

Staff pathologists. Abnormals are reviewed daily by our full-time staff pathologists. Any significant abnormal is immediately retested at no charge and the confirmed results phoned to you. Of course, our pathologists are available for consultation at any time.

Serum retention program. To make it easier for both you and your patient, every serum specimen is frozen for one week after initial testing. If further testing is necessary, just call us.

Accuracy assistance. We can assist you in training your personnel in laboratory procedures and proper specimen handling. Proper collection, handling and submission at your end further ensures accuracy at ours.

We're CBC and we've got a lot more to offer you. Our service is comprehensive, convenient, fast, and most important . . . accurate. Take the time to take our test. It may be one of the best things you ever do for your patients. And we *can* prove it.

To put us to the test call:
1-800-632-0706.

CBC
CONTINENTAL
BIO-CLINICAL
LABORATORY SERVICE, INC.
Grand Rapids, Michigan • Toledo, Ohio
Mishawaka, Indiana

DOCTOR WALKER/*Continued*

District of Columbia Medical Society certainly impressed upon me the important role which the medical profession can play in the promotion of occupational and environmental health services.

That role is increasing as our society grows more complex and as advances in health sciences become more embedded in a changing social context, not the least of which is a burden of illness profile that shifted significantly in recent years.

As MSMS appropriately pointed out in its **"Guidelines for Evaluating Candidates for the position of Director, Michigan Department of Health:"**

> ". . . the Department of Public Health is by nature a regulatory department."

But we are fully aware that a much disputed issue during this decade is the efficacy and appropriateness of government regulation; not simply of business but as it affects all aspects of private life from environmental pollution to consumer protection.

As I have examined regulatory issues at the local and federal levels, I am struck by the highly adversarial character of both the existing process and the national discussion of regulations. Admittedly, regulation is inherently controversial because it seeks to restrict or prohibit activities that some people value. For example, there is the traditional and fundamental relationship between patient, physician and health facility. Simply exhorting opposing sides to good will toward each other is unlikely to produce dramatic changes. A more modest goal is possible — to channel the discussion about regulations into less emotional and more productive directions.

Moreover, while an outright repudiation of all regulation is not likely, we can and shall move toward the use of less intrusive, more efficient regulatory techniques whenever government intervenes.

In this direction, Governor Milliken has already established a task force on regulations, which is chaired by Lt. Governor Brickley. MDPH is represented on that task force.

We recognize that regulation is frequently a response to real problems and that wholesale removal of government control would be irresponsible.

But we are undertaking a systematic analysis of regulatory issues so that points of conflict are set in relief and resolved on the terms acceptable to both the regulators and those who are regulated.

Finally, at a very early date I expect to meet with your Committee on Public Health to develop an agenda of items for which we will want some early and on-going assistance from the Society.

(Editor's note: Doctor Walker did indeed meet with the MSMS Committee on Public Health on Oct. 14. A description of his agenda at that time appears in the Oct. 16 *Medigram.)*

ANNOUNCING THE C.L.I.C.

SPEAKERS BUREAU

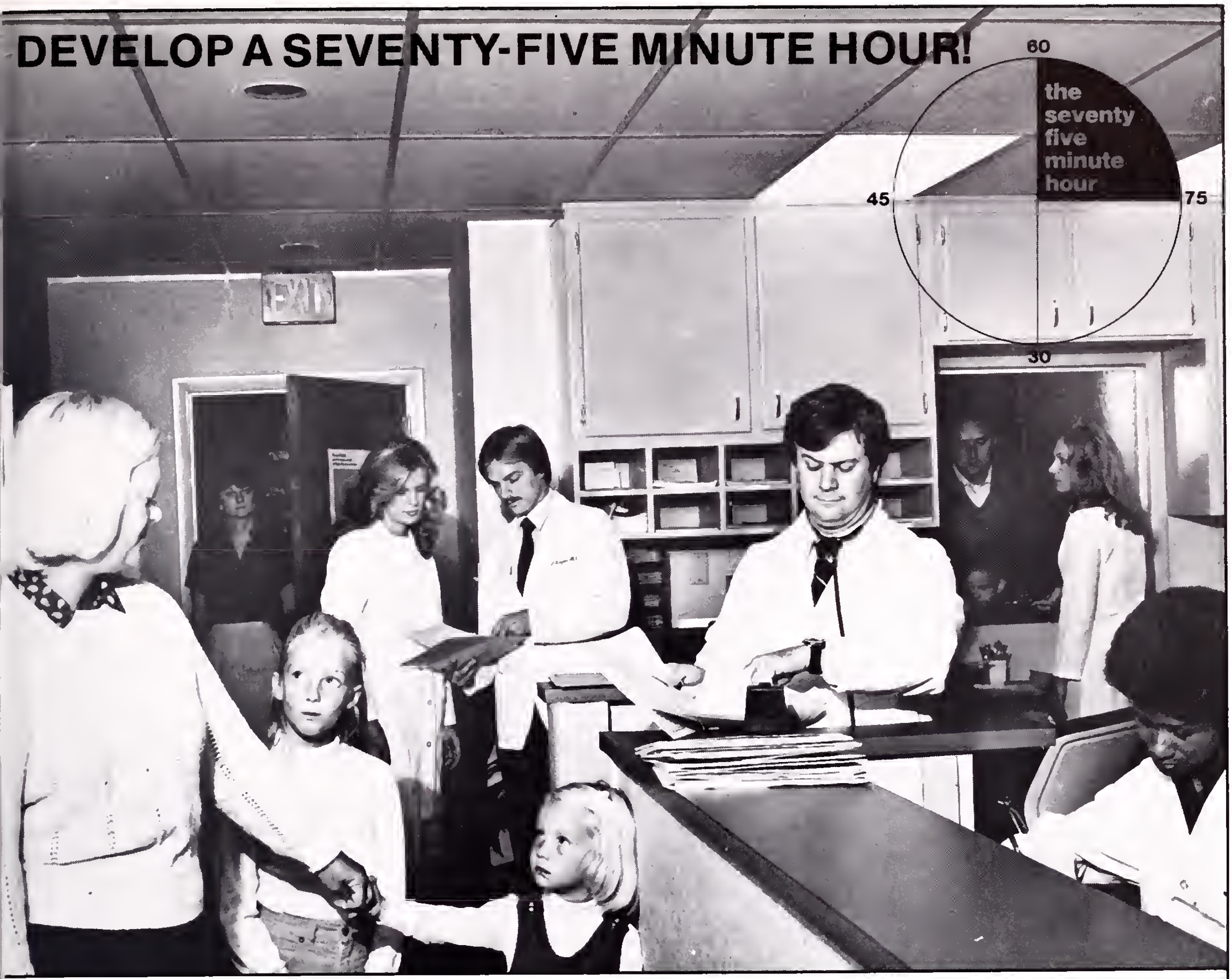
Now scheduling PRESENTATIONS on the following investment topics:

- GOLD & SILVER BULLION
- RARE COINS

To schedule a highly enlightening presentation for your next business meeting, contact:

CARLTON LUSH INVESTMENT CORPORATION
Bingham Center • Suite 1646
30700 Telegraph Road • Birmingham, Michigan 48010
(313) 646-8846

Life Members: ANA, CNA, MSNS


DEVELOP A SEVENTY-FIVE MINUTE HOUR!
60
the seventy five minute hour
45
75
30
EXIT

IN THE MEDICAL PROFESSION, TIME IS ONE OF YOUR MOST VALUABLE ASSETS!
LIGHTCOM medical communications and management systems will maximize the efficiency and improve the daily operation of your practice or health care facility. The light and digital systems are custom designed to meet your special needs and requirements. You are able to see more patients daily in a quieter and more controlled environment. You can communicate with and direct your staff instantly, discreetly with a single touch without knowing their location. All of this equals increased productivity through the most efficient use of personnel and examination rooms... thereby producing a more profitable practice or health care facility.

JOIN THE QUIET REVOLUTION!
LIGHTCOM manufacturers, markets and installs America's leading medical communication and management systems nationwide. Our systems are microprocessor based with patient examination sequence **MEMORY** capabilities.

LIGHTCOM INC

Corporate Offices
5990 Unity Drive
Atlanta (Norcross), Georgia
30071-9990

LIGHTCOM INC
5990 Unity Drive
Atlanta (Norcross), Georgia 30071-9990

Phone:
(404) 447-5926

For more information, mail coupon.

Name ______________________

Address ______________________

City ____________ State ________ Zip ________

Telephone ______________________

Specialty ______________________

County Medical Society Auxilians show great variety in community service

By Mrs. Lawrence E. Grennan
Muskegon

One of the privileges and pleasures of the Michigan State Medical Society Auxiliary presidency is that of visiting county auxiliaries throughout the state. That's when the MSMS/A president meets auxilians on their home ground and learns how they work and in what areas they have concentrated their energies. My visits have just begun, but already I am excited at the ideas and involvements of these active members.

Dickinson-Iron County, which won an AMA/ERF award at the American Medical Association Auxiliary Convention, was the first stop in July. For their cocktail party-jewelry sale, which earned $500 plus ($29.52 per capita for their 18 members) they received a certificate for the most innovative fund raising project in the North Central Region of the AMAA. The members of this dual county auxiliary, though widely separated, work diligently to maintain their integrity as a group of physicians' spouses. They are receptive to new ideas and a delight to meet.

Delta County Auxiliary, which encompasses the cities of Escanaba and Gladstone, was busily engaged in organizing the Upper Peninsula Medical Society Auxiliary activities for their scheduled meeting on Mackinac Island in September. The membership of this county numbers 28 and all were involved in this big project.

President Lynn Dehlin and her auxilians did a fine job, as I personally discovered subsequently when attending the meeting. They set up a three hour seminar on emergency medicine for those attending, as well as Jazzercize sessions, in addition to making the other arrangements necessary to a meeting like this in the Grand Hotel.

In September the **Kent County** Auxiliary board members displayed their involvement at their first board meeting of the Fall. A Sale-A-Rama planned to raise funds for their projects; *Heartbeat*, their newsletter; AMA/ERF projects; special interest classes; Kent Medical Foundation; Citizens Advisory Committee to Kent County Juvenile Court; Project Charlie: house staff liaison and participation in the October Medicare Seminar were among the multiple items on their business agenda.

These auxilians are more than active and involved; they are fantastic! Author Carla Fine, "Married to Medicine, Intimate Portrait of Doctors Wives," has been scheduled to speak at their October meeting while AMA President Daniel Cloud, MD, will be featured in November.

Muskegon County auxilians will be avoiding lobster pincers when delivery of the pre-ordered crustaceans is made in late October as part of their fund-raising efforts. October will also see this auxiliary unveiling their new Soup and Salad cookbook. These money makers finance auxiliary projects such as the two new health care programs underway: a pamphlet on nutrition for school children (to supplement their successful "Is He Sick?" brochure of guidelines for parents of K-3 students) and a campus rape awareness program for college-bound senior high school girls. Muskegon auxilians also are engaged in planning the 1982 MSMS/A State Convention to be held May 3, 4, 5 at the Amway Grand Plaza Hotel in Grand Rapids.

Newaygo's nine auxiliary members are gearing up for their Fall Bloodmobile, scheduled for Oct. 24. These women have organized this community project as an auxiliary four times a year for several years. It is their primary interest for this area and utilizes the talents and time of their 100 percent county membership.

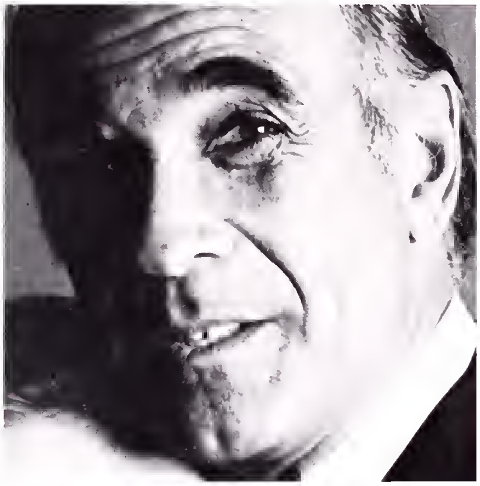
Wayne County auxilians will host their meeting in October at the Edsel and Eleanor Ford home in Grosse Pointe. This auxiliary last year raised $40,000 for medica scholarships through a combined dinner-dance and art auction Though a large auxiliary with many demands on its members, they stil produce marvelous results from thei many projects.

Macomb County has invited state officers to their November meeting at which they will provide th program. Michigan State Medical Society Auxiliary activities will be featured.

The honor of visiting these counties and the others which represen the Michigan State Medical Societ Auxiliary is a great one.

Mrs. Grennan is president of the MSMS/A.

NOW THAT HIS
EDICAL PROBLEM IS GONE...



SO IS HE.

When one of your patients fails to pay, it's tough to collect. But when he moves out of state, it's next to impossible. That's why your association approved I.C. System – a nationwide collection service. Whether a debtor has moved across town or across the country, let I.C. cover the extra miles for you. Mail this coupon today to learn how far...

The System
Works

I.C. COLLECTION SERVICE
Michigan State Medical Society
120 West Saginaw
East Lansing, Michigan 48823

Name ____________________
Address ____________________
City ____________________
State ____________ Zip ____________
Signature ____________________

How to reduce your accounts receivable without lifting a finger.

If your accounts receivable look like the National Debt, don't blame the economy entirely. Your billing system might be part of the problem. Late statements mean late collections. Error-prone or ambiguous statements collect complaints instead of cash.

The Control-o-fax Statement Service eliminates these problems. This service gets your billing out on time every time. And each statement is the exact "picture" copy of your ledger card.

Our Control-o-fax Statement Service clients have reduced their accounts receivable significantly without lifting a finger. Call for full details.

Detroit Area:
Creative Systems, Inc.
18280 W. Ten Mile Rd.
Southfield, MI 48075
(313) 352-9425

Control-o-fax®
STATEMENT SERVICE

Outstate Michigan:
Reed Office Systems, Inc.
2883 East Paris Avenue
Grand Rapids, MI 49508
(616) 942-7400
LANSING 482-0200 FLINT 238-7447
TRAVERSE CITY 941-7771
SAGINAW 752-8802

Just Published.

The first medical-legal reference book specifically for Michigan.

Written in plain English —for preventive legal medicine.

A comprehensive survey of the laws affecting your practice of medicine in Michigan—with informed legal comment.

Clothbound, 480 pages, $50.00. Order No. 00839, ISBN 0-914904-71-X

THE LAW OF MEDICAL PRACTICE IN MICHIGAN

By J. Douglas Peters, J.D.
Keith S. Fineberg, J.D.
Donald A. Kroll, M.D., Ph.D.

ICLE

Available from:

Health Administration Press
Department TH
1021 E. Huron
The University of Michigan
Ann Arbor, MI 48109

Order Form

Yes! Please send me a copy of The Law of Medical Practice in Michigan.

Name ____________________

Title ____________________

Institution ____________________

Address ____________________

City ____________ State ____________

Zip ____________________

☐ Check Enclosed ☐ Bill Me

☐ Bill Institution (P.O. No. ____________)

YOUR
INCOME
Employees' Salaries
OFFICE RENT
Utilities

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc. Check these features of the Professional Overhead Expense plan sponsored by the MSMS.

- ☑ Up to $3,000 monthly benefit
- ☑ Waiver of Premium
- ☑ Survivors' Benefits
- ☑ Professional liability premiums are a covered expense
- ☑ Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more

"we're here to help"

Stratton–Cheeseman & Associates, Inc.

1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823
Call Toll Free: **800-292-1966**

*1979. The National Underwriter Company

MSU's entering medical class over 50 percent female

By Nan M. Houston
East Lansing

The trend in some medical schools to admit more women was underscored dramatically this fall with the announcement from Michigan State University's College of Human Medicine that women medical students outnumber the men in the 1981 entering class.

The medical college dean, W. Donald Weston, MD, addressing an orientation session for new students, announced that 55 of the 106 MD students in the 1981 entering class are women.

"This is a first for Michigan and the Midwest," he told the first year students, "and until now an achievement recorded by only two of the nation's 123 four-year medical schools."

(Last year, the Medical College of Pennsylvania, formerly the Women's Medical College of Pennsylvania, had an entering class of 62 percent women, and in 1976 the State University of New York (SUNY) at Stoneybrook enrolled 28 women in an entering class of 50.)

Total enrollment in the College of Human Medicine for the 1981-82 academic year is 440, including 193 women. Since graduating its first M.D. in 1982, the college has conferred 832 doctor of medicine degrees, 243 of them to women. When the college was founded in 1964, it was Michigan's first new medical school to be established in more than 100 years.

No special consideration

Dean Weston emphasized that the MSU College of Human Medicine admissions process gives "no weight" to gender of its applicants.

"We have publicly stated our goal of 40 to 50 percent women in the entering classes," he said, "and we've been able to attract them without any special consideration in the admissions process."

Women made up 47 percent of last year's first-year class at CHM, 46 percent in 1979, and 35 percent in 1978.

The medical school's assistant dean for student affairs and admission, John B. Molidor, PhD, reports that this year's entering class of 106 was selected from 2,112 applicants and includes 17 percent minority representation. Their average age is 25½ years, their undergraduate majors include biology, psychology zoology, microbiology and chemistry. The majority (85 percent) of the class is from Michigan.

Describing the medical college's process, Doctor Molidor said new medical students are selected after careful study of their entire applications and interviews, including assessment of academic qualities, personal qualities, and health or socia care participation.

"The admission committee looks for those students who admirably demonstrate the ability, achievement character, and motivation to bes function in the programs of the College of Human Medicine," he said.

Views on medicine — medica education — and women in medicin were garnered via interviews wit three graduates of the College o Human Medicine (two participatin in Lansing, one in South Lyon) an three women medical students takin clinical clerkships on CHM campuse in Flint, Kalamazoo and Lansing.

First woman

The first woman to earn an MI degree (1972) at Michigan State Uni versity, Barbara Fogle, is a famil practitioner in South Lyon. Now Doc tor Mercer, she is medical director o a remote satellite of Southfield' Providence Hospital, and on the hos pital's teaching staff for the famil practice residency program. Abou one-third of her residents are women.

She thinks her early interactio with patients in MSU's medica school helped to engender in her sensitivity to human feelings, nc only in patients but with other stu dents and with faculty.

This early interaction, combine with the MSU College of Huma Medicine's efforts to teach student to build a good, communicativ doctor/patient relationship "made fo a very valuable foundation in inte personal skills," she said.

"The ability to deal with patien

Ms. Houston is editor, Medicine and Health Information, MSU University Relations.

Fact:

One out of ten drinkers is an alcoholic.

The important fact to remember is that alcoholism, when properly treated, can be arrested. Our primary goal at Insight is to help people understand and deal effectively with their alcoholism — through intensive, short-term therapy in a residential setting and a planned aftercare program involving families, employers, A.A. and other significant support groups.

For more information, call or write:

INSIGHT AT COLOMBIERE
9075 BIG LAKE ROAD, POST OFFICE BOX 258
CLARKSTON MI 48016 TELEPHONE (313) 625-0400

JCAH ACCREDITED
A PROGRAM OF INSIGHT INC

octor *Gale*

Doctor *Lane*

s whole human beings is the best nswer to any malpractice crisis," he said. "It's important to everyone oncerned to take time to explain to atients what is going on — and vhy."

Doctor Mercer believes there is a rowing segment of practicing hysicians who deal with patients as artners in sharing the major deci-ions in health care, even though here are times when patients need — nd want — a directive kind of ealth care.

"Most," she says, "desire an qual role in medical decision mak-ng."

She believes it is "hard to train hysicians, but the College of Human edicine tries harder than most med-cal schools. And the school really osters and tries to preserve the med-cal students' idealism."

cceptance could improve

Deborah Lane, MD, CHM '77, fter an ob-gyn residency at Flint's Iurley Medical Center, began her ractice last May in Lansing. She is n associate of Oliver Beamon, MD.

She selected Lansing as her prac-ice site because of friends in the area nd ties with the University — she ook pre-med work there and earned BS in microbiology.

"Practice is more rewarding than ever anticipated," she said. "So nany of my new patients have never ad a woman physician and say they re 'so glad' to have a woman doc-or."

She does acknowledge that ac-eptance of women in the surgical subspecialties "could be improved."

Other obligations, interests

Alice Gale, MD, a '76 graduate now practicing dermatology in Lansing, appreciates the CHM perspective on people in medicine being more than just good physicians.

"The school seems to lend itself nicely to students — women and men — who have several interests and other obligations in life in addition to medicine," she said.

"I also appreciate my medical school's emphasis on lifelong self-instruction and small group learning."

Doctor Gale, who interned with Graduate Medical Education, Inc., in Lansing before taking a residency at Detroit's Henry Ford Hospital, thinks strong interpersonal skills are among the most important in being a physician, and finds them "of large benefit" with her patients.

Not a wife

Margaret Gregory, Class of '83, is taking her clinical clerkship (years three and four) on CHM's community campus in Lansing, where she lives with her family — husband and three children (two are grown).

"The dynamics of being female and in medicine is not just one issue, but a complicated process," she believes. "Being female is a bonus, but it carries with it obligations for child care and other family expectations that are not always borne by the male medical student."

Mrs. Gregory thinks spouse expectations are different for women medical students and women doctors than they are for their male counterparts.

"Spouses of female doctors have to be a 'different breed' in order to accept a dual career family," she said. "And a male spouse is NOT a wife!"

She credits her husband with being extremely supportive, and reports he and other family members took on cooking chores for three months so she'd have extra time to study for boards.

"Lovely as this was, I wonder sometimes how many men medical students have to make special domestic arrangements to garner additional study time — although I know many of them are also carrying extra obligations," Mrs. Gregory said.

Women's potluck programs

Mary Miller, a Kalamazoo-based student who'll get her MD from MSU in '84, recalls with pleasure the women's potluck programs during her East Lansing years as "good opportunities to communicate with other women students."

She feels most interactions with faculty are very supportive and says "my student colleagues also give me lots of support, which I really appreciate, particularly since my husband is living in California."

One thing that bothers her is that the move to the community campuses (Kalamazoo, Lansing, Saginaw, Flint and Grand Rapids) means that many close friendships are being geographically divided.

"I'm glad to get into the clinical clerkship years," she said, "but I do

MSU WOMEN/*Continued*

MSU's Flint campus has Women in Medicine group

The Women in Medicine organization for Flint students, residents and physicians gives its members a chance to meet over lunch and share common problems, new insights and a laugh or two. From left are Susan Andrews and Raenette Palmer.

What it's like to be a woman in a man's field — what it's like to juggle family, husband, and medical school — and even what it was like to be a woman medical student years ago — are some of the topics that form the fabric of a Women in Medicine support group newly organized in Flint.

Members of the group, launched under the auspices of the Flint campus of the College of Human Medicine, included medical students, residents and interns, and practicing physicians, some 100 women in all. Ages range from the mid-20s to the mid-70s. There is no formal structure at the moment, just informal get-togethers in private homes (and the networking that ensues) and rich opportunities to discuss subjects of mutual concern.

Impetus for starting the Women in Medicine group was the news last spring that 14 of the 20 third-year CHM students, due to arrive at the Flint campus by September, would be women.

"We felt they could encounter special problems and have special concerns, and would be likely beneficiaries of a women's support group," stated Geraldine M. Purcell, PhD, assistant dean for the College of Human Medicine Flint campus.

Doctor Purcell

"We had the first meeting of Women in Medicine before the new students arrived. We talked about role models, problems, concerns of our present women students and women physicians, plus possible problems facing the new women students," she said.

The second meeting was held after the summer students arrived the third in October. Meeting sites have been homes of Dorothy Mulkey MD; Phyllis Helcher, MD, and Sharon Dowd, MD.

In addition to day-to-day issues facing woman doctors and medica students, a few global problems also receive attention. Topping this list is the proposed "Family Protection Act" and how it would adversely affect not only women in the professions but other working mothers and fulltime homemakers as well.

Doctor Purcell credits one of he assistants, Raenette Palmer, Flin campus student affairs coordinato who has a degree in sociology, as "major mover" in organizing the new Women in Medicine group.

Statistically, with the arrival from the East Lansing campus of th new third-year class, women now dominate the total enrollment of College of Human Medicine students in Flint. Of the 39 students, 24 ar female.

MSU WOMEN/*Continued*

miss a lot of my friends who went t other communities."

Different sorts of problems

Teresa Goetz, CHM '84, is takin her clinical years on the Flint campus. She believes the medical scho gives much encouragement to i students and that "men in medicin need support, but women do face di ferent sorts of problems."

She is just beginning her thi year and finds time at a premium, much so it often is difficult for her get to know her patients very well.

"I do try, however, because I b lieve rapport is so important to strong doctor/patient relationship she said.

Ms. Goetz said she felt h teachers, at least some of them, mu find it quite "different" to encount so many women medical students.

"I was in a Fundamentals of P tient Care group at St. Joseph Hosp tal that was entirely women. A eight of us!" she said.

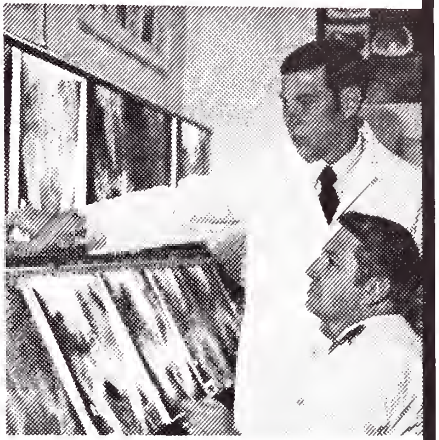
AN ATTRACTIVE ALTERNATIVE TO PRIVATE PRACTICE — AIR FORCE MEDICINE

Did you go to medical school to become a doctor or an office manager, supply clerk, or repairman? If you want to concentrate on your medical practice and leave the administration to someone else, then Air Force medicine can be an attractive alternative to your private practice. You see, the Air Force uses a group practice system of health care. This system allows maximum contact between patient and physician with a minimum of administrative responsibilities. Nurses and technicians take care of the paperwork while you take care of the patients. You'll get to use the skills gained through years of education; to stay abreast of new methods and techniques; and, for qualified physicians, to specialize. These benefits, along with our excellent employment package, make Air Force medicine an attractive alternative to private practice. Find out how you can be a part of the Air Force health care team. We'll answer all your questions promptly and without obligation.

Contact 23400 Michigan Ave., Village Plaza, Dearborn (313) 561-7018; in Lansing (517) 372-3133.

AIR FORCE

A great way of life



Administrative office and main laboratory

AMRC the full service laboratory

- **Complete range of individual tests and diagnostic profiles**
- **Medical consultation services**
- **Comprehensive quality control program**
- **Fully accredited**
- **Complete billing service**

Advance Medical &
Research Center, Inc.

1270 Doris Rd • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

Behind the desk reference cards

By Roger Postmus, MD
Ypsilanti

In this issue of *Michigan Medicine* is a copy of the revised Maternal Health Desk Reference Card No. 7 dealing with the subject of Hypertensive Diseases of Pregnancy.

Perhaps you have noticed that two or three times each year similar cards are distributed in *Michigan Medicine* which are intended to serve as a basic and up-to-date reference source, dealing with current and common subjects related to the practice of obstetrics.

Since they were first begun in 1968, the cards (26 as of this date) have all been written by members of the Maternal and Perinatal Health Committee, a subcommittee of MSMS, or by consultants with special knowledge of the particular subject covered by that card.

Outdated cards are revised as thought appropriate by members of the committee.

Often cards that cover subjects which can be controversial take more than a year to complete. As many as four or five drafts may be required before the cards reach a form acceptable to the committee. Each sentence, each phrase and even each word is critically considered at meetings of the committee.

Every committee member is welcome to constructively criticize freely and openly or suggest changes in content, sentence structure and even punctuation. The author of each card under discussion must have a sense of humor, must be tolerant and be prepared to have his card criticized, torn apart, or even discarded altogether. The open and frank discussions relating to the preparation of the cards have led to mutual appreciation and a sense of loyalty and closeness among the committee members.

This educational function of the Maternal and Perinatal Health Committee, under the Chairmanship o Lee B. Stevenson, MD, is one of the more visible functions of the committee. The preparation and circulation of these Desk Reference Cards involves considerable time, effort and expense, and will continue as long a the committee believes the cards ar being used by and are useful t MSMS members.

We welcome suggestions for new cards and suggestions for improvin the existing cards. Individual card or the complete set can be obtaine upon request from Katie Brewbake MSMS, 120 W. Saginaw St., Ea Lansing 48823.

Doctor Postmus is an obstetrician/gynecologist, and is chairman of the Education Subcommittee of the MSMS Committee on Maternal and Perinatal Health.

Microbiological Systems for the Physician's Office

- Troy Biologicals offers a variety of culture systems that enable the physician to perform a culture and sensitivity on different specimens (throat, urine, vaginal, wound, skin, etc.).
- *The Quad Plus System* is an all purpose system which includes a (1) quad plate for identification purposes, (2) a Mueller Hinton plate for sensitivity testing, (3) antibiotic discs, (4) swabs and (5) patient report pads. Pricing for the *Quad Plus System* begins at $1.99 per system. Quantity discounts are available.
- Specialized bi-plate and tri-plate systems are also available for throat and urine specimens. Troy Biologicals also offers a complete line of standard plates and tubed media, such as T.S.A. with 5% sheep's blood, E.M.B. agar, MacConkey agar, etc. Contact us for a price quote.
- A complete set-up is available upon request. Troy Biologicals carries a full line of related microbiological supplies such as incubators, loops, alcohol lamps, swabs, culturettes, disc dispensers, etc.
- A *Workshop in Clinical Microbiology* is also available to those who need additional training.
- Call for a complete price list and colored brochure.

TROY BIOLOGICALS, INC.
6107 E. Ten Mile Road • Warren, Michigan 48091
Call Collect: (313) 759-4530

Updated Maternal Health Desk Reference Card No. 7

(Sponsored and prepared by the Committee on Maternal and Perinatal Health,
Michigan State Medical Society.)

HYPERTENSIVE DISEASES OF PREGNANCY

Elevated blood pressure may arise as a result of pregnancy (pre-*eclampsia*), convulsions may appear (*eclampsia*), or previously existing blood pressure elevation may be aggravated by pregnancy (*chronic hypertension with superimposed pre-eclampsia*). *Transient hypertension* may appear postpartum in a previously normal pregnant woman.

Hypertension is a common denominator for several physiopathologic conditions. Pheochromocytoma and systemic lupus erythematosus represent infrequent situations necessitating special diagnosis and treatment plans in special care centers.

Pre-eclampsia is a disease peculiar to pregnancy and is characterized by hypertension and frequently associated with proteinuria. It appears in a pregnant woman after week 24 of gestation. Rapid weight gain in excess of 4.5 kg/week constitutes an indication to rule out hypertensive disease of pregnancy.

Eclampsia is the appearance of significant central nervous system disturbance (generalized tonic-clonic convulsions), and/or coma (stupor, confusion) in a patient with pre-eclampsia.

Chronic (primary) hypertension is frequently associated with decreased kidney function, repeated pregnancy losses, intrauterine growth retardation, abnormal urinanalysis. Pre-existing hypertension may remain unchanged or be exacerbated by the coexisting pregnancy.

PRENATAL CARE

Signs of *pre-eclampsia* during the first trimester mandate immediate efforts to detect a possible molar pregnancy, multiple pregnancy or hydramnios.

Young primigravidas are especially prone to develop pre-eclampsia. Older primigravidas are prone to develop pre-eclampsia superimposed on chronic hypertension. Elderly multiparas are also at increased risk for pre-eclampsia.

Identification and differentiation of those conditions is mandatory for optimal care. This care should include a program of more frequent prenatal visits and occasionally in-patient evaluation is indicated. Clinical observation should be supplemented by studies of renal function, fetal growth and well being, maturation and placental function.

This Reference Card was written for the Maternal and Perinatal Health Committee by Federico Mariona, MD, Detroit, Michigan.

The above Desk Reference Card describes methods and techniques of clinical practice that are currently acceptable and used by recognized authorities. However, it does not represent official policy or recommendations of the Michigan State Medical Society and its publication should not be construed as excluding other acceptable methods of handling similar problems.

DIAGNOSIS

1. A 30 mmHg increase in systolic blood pressure and/or 15 mmHg increase in diastolic pressure above prior levels. Remember the physiologic drop in blood pressure that normally occurs in midtrimester. (Levels such as 120/80 can reflect hypertension.)
2. Proteinuria (detected in a midstream clean catch or catheterized urine specimen).
3. Edema (hands and face).

CLINICAL FORMS

MILD PRE-ECLAMPSIA

Blood pressure up to 140/90.

MODERATE PRE-ECLAMPSIA

Blood pressure up to 150/110.

SEVERE PRE-ECLAMPSIA

Blood pressure of 160/110 on two separate occasions, on bedrest, lateral supine, taken 6 hours apart. Proteinuria 3 or 4+ (300 mg/L). Visual disturbances (scotomata); CNS irritability; oliguria (<400 ml urine/24 hours); headache; epigastric pain; moderate to marked generalized edema).

TREATMENT

A. AMBULATORY

1. Selected cases of mild pre-eclampsia may be treated in the following manner.
    a. Prescribe bed rest in either lateral recumbent (preferably *left* side) for a total of 12 hours daily.
    b. Adequate diet (1.5 gm protein/kg of body weight). Salt to taste (2 gm of salt). NO ADDED SALT.
    c. Frequent medical examinations (twice weekly). Fetal movements and activity evaluation.
    d. If no response or poor compliance, HOSPITALIZE.

B. IN HOSPITAL.

1. Absolute bed rest, lateral recumbent position.
2. Consult obstetrician or maternal-fetal medicine specialist. Notify Pediatrics.
3. Laboratory studies to include CBC, clean catch midstream urine for protein, culture and sensitivity. Individualize the need for chemistry profile (BUN, uric acid, creatinine, bilirubin, total protein, serum electrolytes).
4. 24-hour urine collection for quantitative protein determination and creatinine clearance.
5. Qualitative urine protein determination every shift.
6. Blood pressure every 4 hours except when the patient is sleeping. (Remember the physiologic nocturnal hypertension of the pre-eclamptic). Use an appropriate sized cuff. *Check blood pressure always in the same position, and apply cuff in the same area.*
7. Record intake, output, daily weight.
8. Regular diet. No fluid restriction (see above).

9. With a gestational age exceeding 36 weeks, complete the evaluation, stabilize and deliver.
10. If cervical conditions are favorable, initiate oxytocin induction under careful continuous monitoring. If said conditions are unfavorable or fetal distress ensues, deliver by cesarean section.

If a Neonatal Intensive Care Unit is not available or the pregnancy is below 3 weeks, *stabilize* the mother, sedate, consult with obstetrician/maternal-fetal medicine specialist and transport the patient to appropriate referral institution.

C. SEVERE PRE-ECLAMPSIA. (Diagnosis: see clinical forms above.)

1. Hospitalize. Intensive Care Obstetrical Unit. Cardiovascular evaluation (chest x-ray, EKG).
2. Consult obstetrician or maternal-fetal medicine specialist. If OB ICU facilities are not immediately available, evaluate CNS irritability, *stabilize*, sedate and transport.
3. Alert Anesthesia. Notify Pediatrics.
4. Adequate IV lines (including central venous or pulmonary wedge pressure as available). Bedside x-ray control of catheter position is necessary.
5. Laboratory studies; hemoglobin, hematocrit, uric acid, fibrinogen, platelet count, fibrin split products, BUN, bilirubin, serum electrolytes, serum creatinine.
6. Blood type and antibody titer. Have blood available.
7. Blood pressure monitoring every 15 minutes.
8. Foley catheter. Hourly record of intake and output.
9. Keep vein open with 5 percent dextrose in Ringer's lactate. Titrate intake according to output. Do not exceed 10 gm glucose/hour.
10. Urine specific gravity every shift.
11. Semi-Fowler position, lateral tilt.
12. Magnesium sulfate, 4 gm I.V. (.5 gm/minute) bolus, followed by continuous infusion of 1 gm/hour by pump. Check reflexes every 15 to 30 minutes and respiratory rate and bolus doses of Magnesium sulfate IV as needed to maintain hypoactive reflex or respiratory rate 16 or above. Oliguria demands Magnesium sulfate use.
13. Hydralazine. IV bolus (5-10 mg) and observe response. Do not reduce diastolic more than 25 percent of pre-injection level. May be followed by IV infusion for maintenance.
14. Evaluate inducibility.
15. Deliver within 24 hours.
16. Prevent (avoid) convulsions at all costs.

D. FOR ECLAMPSIA.

1. Hospitalize immediately. Obstetrical ICU.
2. Consultants.
3. Maintain airway. Intubate if unable to maintain properly.

4. Oxygen given by tight face mask or respirator.
5. If seizure activity is present, utilize:

   1st choice:

   Loading dose of magnesium sulfate according to schedule. Check reflexes and respiratory rate every 15 to 30 minutes. Reflexes must become hypoactive. Respirations/minute no less than 16.

   2nd choice:

   Sodium amytal 125-250 mg, IV bolus in 2-3 minutes.

   3rd choice:

   Diazepam (Valium) 5 mg. IV bolus and increments of 1 mg until activity decreases.
6. Suction at bedside.
7. If still undelivered, treat as for severe pre-eclampsia.
8. Post-convulsion skull and other indicated x-rays.
9. Stabilize and deliver as soon as possible after patient recovers consciousness (±2 hours). Have personnel capable of immediate full neonate resuscitation present at delivery.
10. Keep patient in OB ICU minimum 48 hours post-delivery.

E. FOR CHRONIC HYPERTENSION.

1. Identify by personal, family, medical and obstetrical history. Obtain cardiorenal-vascular evaluation.
2. Substantiate by fundoscopy, urinalysis, early and repeated blood pressure readings. *(Warning on blood pressure readings as above.)*
3. Consult obstetrician or maternal-fetal medicine specialist.
4. Monitor fetal growth by serial ultrasounds. Most favorable period for evaluating growth is 16-30 weeks if biparietal diameter is to be utilized. Various other techniques are currently utilized.
5. Manage chronic hypertension and obtain consultation as appropriate.
6. Prolonged hospitalization may be necessary. Prescribe minimal physical activity. (lateral recumbent position).
7. Repeat kidney function tests in each trimester (serum creatinine, uric acid, creatinine clearance).;
8. Instruct patient in recording fetal motion one hour every day starting at week 28. Proceed to antenatal electronic testing (fetal activity cardiac acceleration, contraction stress test as indicated).
9. Clinical measurements of fundal height and estimated fetal weight are essential. Amniocentesis to estimate fetal maturity if signs of fetal growth retardation or chronic distress are detected.
10. Observe for superimposed pre-eclampsia. Treatment as above.
11. May necessitate early delivery by least traumatic modality. Discuss neonatal outcome of preterm delivery.
12. Discuss family planning.

Does the rise in the prime rate cause a rise in your blood pressure?

International Diamond Corporation
offers fine diamonds, a safe and secure asset for the '80s.

The 1980s promise to be a time of financial insecurity, high inflation, up-and-down gold prices and stock market instability. Only investment quality diamonds offer investors a steady, nonvolatile way to store wealth and increase your investment value.

International Diamond Corporation, the leader in investment diamond services, protects your investment safely and securely with:

- Insured grade accuracy, guaranteed in writing
- 10-year history of successful liquidations (resales)
- Audited records of profits to our customers
- Up-to-date computerized market reports
- The IDC "diamond banking" service, including the exclusive IDC Passbook Account to record your diamond acquisitions

Please contact one of our District Managers in your area to learn more about "diamond banking."

Armand Dion	Flint	313-232-4470
John Burns	Troy	313-588-7730
Richard Foster	Adrian	517-265-3530
Paul French	Three Rivers	616-273-9537
Roger Jones	Lansing	517-323-7314
Dan Junttila,	Calumet	906-337-0500
Arnie Peterson,	Calumet	906-337-0500
Bernie Sementelli,	Flint	313-232-6820
Fred Berkman,	Bay City	517-893-9243
Ray McDermett,	Traverse City	616-941-4585
Bob Stritzinger,	Grand Rapids	616-459-2863

MICHIGAN REGIONAL HEADQUARTERS
James A. Fannon, 2120 - 44th Street, S.E., Grand Rapids, MI 49508 616-455-4310

International Diamond Corporation

Here are latest data on MSMS malpractice claims study

By Deborah Zannoth
East Lansing

The MSMS Bureau of Economics has reviewed 443 medical malpractice suits completing litigation in Michigan between June, 1980 and June, 1981. These represent any malpractice claims which were settled through the court process in that time period; however, many of the claims were initiated in prior years, some as far back as 1973.

There was a 127 percent increase in claims settled between June, 1980, and June, 1981, compared with those settled between June, 1979 and June, 1980. Although this appears to be an extraordinary increase, it is probably a result of those cases initiated during the malpractice crisis in the mid-seventies which have finally culminated in a judgement.

There are limitations in the compiling of malpractice claims data due to lengthy legal proceedings, and an accurate, up-to-date accounting of current malpractice claims is delayed. MSMS receives malpractice statistics only upon completion of litigation, thus making it difficult to analyze the claims filed until several years later.

Of the total 1,545 medical malpractice suits completing the legal process since 1975, it is difficult to determine those claims which have been dismissed by the court or those which have been abandoned. However, the data does indicate that 42 percent of the total claims processed have no indemnity paid, a figure which has been constant for the past two years.

Presently, only one percent of the total claims that remain in the court system are settled through binding arbitration. But this figure does not represent those claims being adjudicated under the Michigan Arbitration Code.

The Michigan Arbitration Code was initiated on January 1, 1976. As of June 30, 1981 a total of 281 claims were filed, of which 120 have been closed.

A more complete report on the arbitration process will be forthcoming in a *Michigan Medicine* article.

The restrictions in the data make it a formidable task to predict with confidence any meaningful future trends. However, there are a number of items which have remained constant over the last few years.

The total amount of claims processed continues to increase along

Continued on page 626

Ms. Zannoth is assistant to the MSMS Bureau of Economics.

Table I
Claims Characteristics

Year	1970	1971	1972	1973	1974	1975
Number of Claims	5	6	31	77	202	324
Total Paid	$16,667	$44,200	$576,762	$795,676	$1,958,984	$4,177,820
Average Paid	NA	$7,367	$18,605	$10,333	$9,698	$12,895
% With no Indemnity Paid	(4) 80%	(3) 50%	(15) 48%	(31) 40%	(90) 45%	(139) 43%

Year	1976	1977	1978	1979	1980
Number of Claims	330	261	172	91	43
Total Paid	$4,053,481	$2,286,373	$1,497,577	$1,161,012	$129,740
Average Paid	$12,283	$8,760	$8,707	$12,758	$3,017
% With no Indemnity Paid	(129) 39%	(105) 40%	(82) 48%	(35) 38%	(19) 44%

Table II
Distribution by Thousands of Indemnity Paid

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
$ 0- 10	0	2	5	27	72	122	143	124	65	41	20	0
$ 11- 20	1	0	3	8	9	20	20	9	7	4	3	0
$ 21- 30	0	0	1	5	12	11	7	2	4	0	1	0
$ 31- 40	0	1	0	2	3	5	2	4	4	2	0	0
$ 41- 50	0	0	2	2	6	2	5	3	2	2	0	0
$ 51- 60	0	0	1	0	0	3	2	2	0	1	0	0
$ 61- 70	0	0	2	0	1	2	2	1	1	1	0	0
$ 71- 80	0	0	0	1	2	4	2	2	0	0	0	0
$ 81- 90	0	0	1	0	1	0	3	0	2	0	0	0
$ 91-100	0	0	0	0	6	6	3	7	4	3	0	0
$101-200	0	0	1	1	0	10	12	2	1	1	0	0
$201-300	0	0	0	0	0	0	0	0	0	1	0	0

Table III
Claims Reporting Data

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980
Number of Cases	5	6	31	77	202	324	330	261	172	91	43
Average Number of Months — Injury to Report	10	12	17	23	20	21	24	28	27	25	25
Average Number of Months — Injury to Close	85	69	79	72	61	55	52	51	46	39	30
Average Number of Months — Report to Close	75	57	61	48	41	34	48	23	19	14	7

Table IV
Physician Characteristics

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980
Average Age of Physician	32	39	40	39	42	43	43	43	46	45	47
Physician Age Distribution											
30 and under	25%	20%	0	0	1%	2%	1%	0	1%	1%	0
31-40	25%	0	33%	28%	28%	31%	30%	33%	27%	28%	13%
41-50	50%	40%	40%	51%	40%	37%	33%	34%	40%	29%	40%
51-60	0	40%	19%	15%	27%	21%	24%	26%	23%	27%	33%
60 and over	0	0	7%	6%	4%	9%	12%	7%	9%	14%	15%
% of FMGs	N/A	33%	6%	12%	19%	25%	21%	25%	19%	33%	28%
Board Certified	(4) 80%	(5) 83%	(20) 65%	(49) 67%	(141) 70%	(191) 59%	(221) 67%	(153) 59%	(115) 67%	(49) 54%	(34) 79%

Table V
Claims Against Physicians By Type of Practice

Type of Practice	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980
Institutional	0	1	1	0	2	2	3	5	0	0	1
PC/Partnership	0	2	9	24	68	124	124	87	76	38	22
Self-Employed	5	3	20	48	123	180	188	153	87	50	18
Employed	0	0	1	5	7	15	14	13	8	3	2
Intern/Resident	0	0	0	0	0	0	0	0	0	0	0

with the average indemnity per claim. However, of the 443 claims processed between June 1980 and June 1981 the average indemnity per claim decreased by $1,700. This figure could merely represent an artifact of data and it is anticipated that the data in the ensuing year will provide some explanation for the decrease.

The average physician involved in litigation remains in his early forties and is self-employed.

Those physicians specializing in general surgery continue to be most often involved in malpractice litigation. One possible hypothesis for this is that surgeons are procedure-oriented and thus exposed more than the average physician population.

The percent of FMGs involved has risen but is not equal to the amount of FMGs currently in practice.

The average period between injury and filing of a claim is 21 months, an increase of 10 percent since the previous year. The average period between injury and closure is 53 months, an increase of eight percent since the previous year. The average period between filing and closure of a claim is 32 months, an increase of three percent since the previous year. These figures represent a gradual increase in the time necessary to complete the court process, a trend which has continued since 1975.

MSMS would like to thank the Michigan Insurance Bureau and the Department of Licensing and Regulation for their assistance in completing this report.

Table VI
Suits by AMA Specialty Classification

General Surgery	559	Cardiovascular Diseases	8
General Practice	251	Otorhinolaryngology	8
Internal Medicine	160	Surgery, Abdominal	8
Surgery, Orthopedic	160	Surgery, Pediatric	8
Radiology, Diagnostic	49	Neurology	7
Surgery, Plastic	43	Rhinology	7
Family Practice	41	Neurology, Child	6
Surgery, Neurological	37	Surgery, Hand	4
Gynecology	32	Allergy	3
Anesthesiology	31	Gastroenterology	3
Surgery, Cardiovascular	20	Surgery, Colon and Rectal	3
Surgery, Thoracic	23	Nuclear Medicine	2
Pediatrics	19	Obstetrics	2
Emergency Medicine	15	Rheumatology	2
Pathology	16	Geriatrics	1
Psychiatry	12	Otology	1
Dermatology	11	Pulmonary Diseases	1
Ophthalmology	11	Surgery, Traumatic	1
Physical Medicine and Rehabilitation	9	Miscellaneous	25

Table VII
Geographical Distribution of Claims

Zip Code	Counties Included	Number of Claims
480	Macomb, Oakland, St. Clair	386
482	Wayne	353
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	240
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	92
495	Kent	53
485	Genesee	43
489	Ingham	40
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	36
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	36
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	34
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	33
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	23
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	20
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	20
484	Genesee, Huron, Lapeer, Oakland, Sanilac	13
487	Alcona, Bay, Iosco, Tuscola	11
493	Kent, Lake, Mecosta, Montcalm	7
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	7
491	Berrien	0
	Invalid Zip Codes	98
	TOTAL	1,545

Table VIII
Average Indemnity Paid by Geographic Region

Zip Code	Counties Included	Indemnity Paid
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	$30,706.00
495	Kent	20,015.00
484	Genesee, Huron, Lapeer, Oakland, Sanilac	16,205.00
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	15,008.00
493	Kent, Lake, Mecosta, Montcalm	14,429.00
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	12,822.00
482	Wayne	11,134.00
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	11,132.00
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	10,568.00
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	10,250.00
485	Genesee	9,521.00
480	Macomb, Oakland, St. Clair	7,718.00
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	5,252.00
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	5,193.00
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	5,003.00
487	Alcona, Bay, Iosco, Tuscola	4,341.00
489	Ingham	3,680.00
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	1,415.00

Table IX
Other Contributing to Injury

Attending Physician	420
House Staff	160
Nurse, RN	50
Consultant	32
Radiologist	20
Patient	13
Nurse, LPN	11
Physician's Assistant	9
Pathologist	8
Radiology Technician	7
Anesthesiologist	4
Laboratory Technician	4
Pharmacist	3
Physical Therapist	3
Aide	1
Orderly	1
Maintenance Personnel	1
Other Personnel	25

INSTANT CURES?

Sometimes there are.

The doctor may not have a bag full of instant cures, but we just might have some instant cures for the doctor. For instance, if your retirement program is an insured plan, we can show you how to cut costs *instantly* by changing to a trusteed plan. We're Watkins, Ross, Baines and Lamps, with some instant cures for problems confronting retirement programs. At WRB&L, we design all types of retirement plans for professional corporations. Once a plan is implemented, our services can provide you with the required actuarial reporting, while we monitor and periodically reevaluate the effectiveness of your program. We're one of the largest actuarial firms in the Midwest and work on an hourly basis.

Sometimes there are instant cures, at least when it comes to retirement planning for professional corporations. Call us. It's just what the doctors order.

WR
B&L

WATKINS/ROSS/BAINES & LAMPS, INC./Consultants and Actuaries
505 Waters Bldg./Grand Rapids, MI 49503/Phone (616) 456-9696
400 Renaissance Ct./Suite 500/Detroit, MI 48243/Phone (313) 568-2222

Do you know

a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?

If so, please contact
your MSMS Committee to
Assist Impaired Physicians
through Marce Ireland at MSMS
headquarters (517) 337-1351

NEWSFRONTS

Enzo Biochem, Inc. has received approval from the Food and Drug Administration to begin clinical trials of its interferon preparation for the topical treatment of herpetic viral infections. The tests, authorized by the Claimed Investigational Exemption, will begin early in September at the Memorial Sloan-Kettering Cancer Center and will involve up to 100 subjects.

The clinical tests of the human leucocyte interferon preparation follow laboratory demonstrations that interferon is an antiviral capable of suppressing Herpes virus. Enzo believes that, if successful, these studies could lead to the development of the first therapeutic interferon product to reach the market.

Kidney transplants are becoming more effective in prolonging life.

One-year survival rate of transplant patients is now close to 90 percent, says a special communication from the Standards Committee of the American Society of Transplant Surgeons.

The Committee reports in the Sept. 18 *Journal of the American Medical Association* on a study of present-day effectiveness of kidney transplants. Official record keeping was ended in 1974, when one-year survival ratio was around 72 percent.

Results of kidney transplants performed at seven centers in 1977 and 1978 were evaluated.

The Committee credited the improved survival ratio to sophisticated use of drugs and treatment to suppress the body's inclination to reject foreign organs and to prompt, accurate diagnosis and treatment of complications.

Arthritic sufferers who daily have to consume large amounts of pain killing medications now may obtain the same immediate relief by way of the recent development of a new once-a-day antiarthritic tablet.

The drug, called Trilisate, a non-acetylated, non-steroid, type antiarthritic tablet is the only anti-inflammatory in the United States with a once-a-day dosage, and is also the only liquid antiarthritic available on prescription.

Trilisate Tablets are available as Trilisate 500 Tablets (500 mg.) and Trilisate 750 Tablets (750 mg.), and are a product of research and development of The Purdue Frederick Company, producers of ethical pharmaceuticals.

The pneumonia vaccine licensed four years ago has not proved useful, says a report in the Sept. 25 *Journal of the American Medical Association.*

In the same issue of the Journal is an editorial pointing out that the **influenza vaccine** has indeed been proved helpful and should be administered to many Americans.

And still a third report assesses the risk of giving the **German measles vaccine** to pregnant women. It concludes the risk is small, but still is not zero and thus the vaccine should not be administered to expectant mothers.

The roundup of articles reporting on several of the available vaccines comes in the fall, as the nation is once again approaching the season of colds, influenza and other winter respiratory infections.

"Images of Life," a new 28-minute public education motion picture, has been released by the American College of Radiology. It is available on a free-loan basis for use by service and civic clubs, health care management and employees, medical institutions, television, students interested in medical-science careers, and general public audiences.

"Images of Life" is available in either 16mm film or ¾-inch videotape cassette format by writing to:

Du Pont Company
Motion Picture Distribution
Service
General Services Department
Wilmington, Delaware 19898

OVER 4,000 POLICYHOLDERS

In five years, we have grown from an idea—to a company insuring over 4,000 physicians with our MEDGARD: PROFESSIONAL LIABILITY, BUILDING/OFFICE PACKAGE, and UMBRELLA coverages. We believe there are good reasons for this. And we'd like to thank the thousands of Michigan Physicians who have supported us.

THANK YOU MICHIGAN PHYSICIANS

THE MEDGARD COMPANY

MEDGARD is not only the name of our policies . . . it represents the major part of MPMLC's philosophy of providing services to physicians. Our insureds have purchased these services to guard their homes, autos, offices, equipment, and, most important, their professional reputations in the event of a claim.

ENDORSED BY ORGANIZED MEDICINE

MPMLC is endorsed by both MSMS and MAOP&S. A distinction not easily gained, nor given to any other carrier which provides professional liability coverage for physicians.

PHYSICIAN OWNERSHIP AND CONTROL

MPMLC is your company. It is owned by physicians and run by physicians. Our Board of Directors is comprised of your colleagues who have practiced medicine in Michigan for years. Several are leaders in other professional organizations at the state and national levels.

EXCELLENT CLAIMS SERVICES

"Keep up the good work"
"Outstanding"
". . . hold MPMLC in high regard."

These are comments from physicians who responded to our Closed Claim Questionnaire. We don't tell you after a claim has been settled. We ask you for your consent first.

YOUR COMPANY THANKS YOU

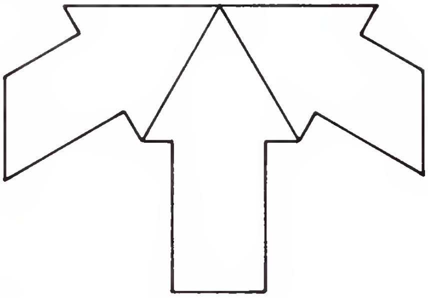
So thank you Michigan physicians for working with us and believing in the concept of your company. We will continue to provide the professional services, diverse coverages, and responsive management which you have supported.

**Michigan Physicians
Mutual Liability Company**

Watch for special announcements about our CME Category I risk management seminar at the MSMS Annual Scientific Meeting. See you in November at the Dearborn Hyatt Regency—Booth 502.

HOME OFFICE. P.O. Box 1471 · East Lansing, MI 48823 · (517) 351-1150 · (800) 292-1926 toll free
SATELLITE OFFICE: 6735 Telegraph Road · Suite 205 · Birmingham, MI 48010 · (313) 647-5550

MEETINGS



MSMS, MSMS/A, AMA medical assistants

Nov. 17-19 — 1981 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry L. Fent, MSMS headquarters.

Dec. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Dec. 6-9 — AMA Interim Meeting, Las Vegas Hilton, contact: AMA headquarters, 535 N. Dearborn Street, Chicago 60610.

Jan. 25, 1982 — MSMS/A Mid-Year Board meeting, MSMS Building, East Lansing, contact: Caroline Rich, MSMS headquarters.

Jan. 27, 1982 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 28-Feb. 11, 1982 — MSMS/INTRAV South American Adventure, contact: Marce Ireland, MSMS headquarters.

Jan. 30-31, 1982 — Medical Assistants Mid-Winter Seminar, Hyatt Regency, Dearborn, contact: Caroline Rich, MSMS headquarters.

Feb. 6-13, 1982 — MSMS/INTRAV West Indies Air/Sea Cruise, contact: Marce Ireland, MSMS headquarters.

March 7, 1982 — Medical Assistants Board Meeting, MSMS Building, East Lansing, contact: Caroline Rich, MSMS headquarters.

March 10, 1982 — MSMS Council Meeting, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

March 10, 1982 — MSMS/A Legislative Day, Civic Center, Lansing, contact: Caroline Rich, MSMS headquarters.

April 8, 1982 — MSMS Conference on Sports Medicine, Plymouth Hilton, contact: Mert Scholten, MSMS headquarters.

April 14-15, 1982 — 1982 Michigan Conference on Maternal and Perinatal Health, Grand Plaza Center, Grand Rapids, contact: Katie Brewbaker, MSMS headquarters.

April 30-May 1-2, 1982 — MSMS House of Delegates, Westin Hotel, Renaissance Center, Detroit, contact: Richard Campau, MSMS headquarters.

May 3-5, 1982 — 56th Annual Convention MSMS Auxiliary, Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

June, 1982 — AMAA Convention, Drake Hotel, Chicago, contact: Caroline Rich, MSMS headquarters.

Other meetings

Nov. 18 — Michigan Society of General Surgeons Annual Meeting, in conjunction with the MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Caroline Rich, MSMS headquarters.

Nov. 18-20 — Special Programs 4 Special Needs, sponsored by the Michigan Rehabilitation Association, Fairlane Manor, Dearborn, contact: Peggy Currie, Ross Business Institute, 21700 Greenfield, Suite 273, Oak Park, 48237, 313/968-1970.

Nov. 24 — "Advocacy Programs for the Aged Mentally Ill," Walter P. Reuther Psychiatric Hospital, contact: W.P. Reuther Psychiatric Hospital, 313/722-4500.

Nov. 26-27 — Management for Supervisors in the Health Care Setting, Four Seasons Hotel, Vancouver, British Columbia, contact: Ingrid Norrish, Conference and Seminar Services, Humber College, Box 1900, Rexdale, Ontario M9W 5L7, 416/675-7420. Repeated Feb. 24-25 at Toronto, and March 15-16 at Halifax, Nova Scotia.

Dec. 1 — Michigan Public Health Association Community Health Division, Livingston County Health Department, contact: MPHA, 407 S. Harrison Road, Suite 340, East Lansing, 48823.

Dec. 3 — Michigan Psychiatric Society Council Meeting, Recess Club, Detroit, contact: Sarah Allison, Michigan Psychiatric Society, 313/552-8666.

Dec. 5 — Eleventh Annual Workshop, Michigan Speech Pathologists in Clinical Practice (MSPCP), Detroit Athletic Club, contact: Christine Sowinski, Oakwood Hospital Audiology & Speech Pathology Dept., 18101 Oakwood Blvd., Dearborn, 48124, or 313/336-3000, ext. 517.

Dec. 15 — "Housing Problems and Issues in Placing the Aged Mentally Ill," Walter P. Reuther Psychiatric Hospital, contact: W.P. Reuther Psychiatric Hospital, 313/722-4500.

April 5, 1982 — Wayne County Medical Society 61st Annual Beaumont Lecture, Bon Secours Hospital, Grosse Pointe, contact: Wayne County Medical Society.

Patients needed

Effect of Biofeedback On Allergy-Related Diseases: A Pilot Study

Several studies have suggested that stress and anxiety are important factors affecting morbidity in several allergy-related diseases. We are investigating whether the pyschophysiological relaxation techniques of biofeedback training can significantly help patients who suffer with bronchial asthma, chronic urticaria or perennial allergic/vasomotor rhinitis.

We are seeking patients whose symptoms are year-round and who are taking medication almost every day for symptomatic relief.

The protocol involves teaching biofeedback with frontalis muscle and digital themistor monitors at the University of Michigan Behavioral Medicine Clinic, one hour per week for 10 weeks. All patients must keep a daily diary, recording both intensity and frequency of symptoms, as well as all medications used, for at least 28 weeks. Outpatient laboratory evaluation will be done both before and after biofeedback training. There will be no charge to the patient as all costs are covered by the research grant.

Physicians should contact either Wiecher H. van Houten, MD, Riverview Clinic, 900 Wall Street, Ann Arbor, 48109 (313) 764-0267; or Jeffrey Tulin-Silver, MD, P.O. Box M-1424, Ann Arbor, 48106 (313) 434-7222.

INTERNIST

Raleigh Hills Hospital located in Miami, Oklahoma has developed a need for an Internal Medicine specialist. This individual will join an outpatient facility associated with the hospital. Our ideal candidate will have a General Medicine background. We offer you a guaranteed income, the potential for revenue sharing, our management expertise and no financial risk on your part. If you feel this might be the spot for you then call either:

Joseph Gagliardi
816-531-0016

Nancy Miner
314-993-9396

Raleigh Hills has several other positions available in locations throughout the Midwest, Rockies and West Coast.

RHH Since 1942
Raleigh Hills Hospitals

MSMS serves physicians in many ways

MSMS represents you and your colleagues in public health and welfare programs.

MSMS interprets you — your training, your motives, your problems, your professional aims and objectives — to your community.

MSMS tries to nurture a favorable public concern toward your profession by helping people to understand and appreciate medicine's contribution.

MSMS guides the development of medical practice in relation to other callings and economic groups.

MSMS protects your legal status as a doctor.

MSMS helps keep medical competition on a professional plane.

MSMS helps your profession to meet its collective responsibilities to the public and avoids the necessity of the public resorting to political devices to solve these problems.

MSMS regularly offers outstanding continuing medical education programs to keep you abreast of the latest and most effective medical theories and techniques.

MSMS provides for you those personal benefits, services, and representations impossible to secure and maintain as an individual.

MSMS helps you to survive and have your voice heard as a responsible professional in an increasingly interdependent and socialized society.

NEWS

By Sheri W. Greenhoe
MSMS staff

Doctor Krause

Doctor Tintinalli

New president of the American College of Emergency Physicians is **B. Ken Gray, MD,** of William Beaumont Hospital in Royal Oak. He was inaugurated during the society's recent annual meeting in New Orleans. . . . **Robert T. Nolta, MD,** Pontiac, was appointed medical director for Fisher Body Division of General Motors in September. He will oversee occupational health programs at 28 Fisher locations in the US. . . . Howell physician **Louis E. "Pat" May, MD,** was honored recently by Clearly College for his more than 30 years of service to the community. . . . Society for Investigative Dermatology awarded the Stephen Rothman Memorial Award to **Isadore A. Bernstein, PhD** for being "an outstanding scientist, a humanitarian and making important contributions to the society." . . . **Sheldon N. Siegel, MD,** is newly appointed chief of the division of psychiatry at the William Beaumont Hospital-Troy and director of its psychiatric consultive liaison service. . . . **Charles J. Krause, MD,** Ann Arbor, is new president of the American Academy of Facial Plastic and Reconstructive Surgery. He is professor and chairman of the Department of Otorhinolaryngology at the U-M. Re-elected as regional vice president was **Robert H. Mathog, MD,** Franklin, chief, Department of Otolaryngology, Wayne State University School of Medicine. . . . **Michael K. Kobernick, MD,** Lansing, was one of 12 family physicians to be named recipients of the 1981 Parke-Davis Teacher Development Awards, designed to stimulate interest in and assist financially those physicians who enter the part-time teaching of family practice following the completion of their family practice residency. . . . **E. Dennis Lyne, MD,** of Franklin, has been elected physician-trustee of Henry Ford Hospital, where he is head of the Division of Pediatric Orthopaedic Surgery. . . . **Gerald Goodlow,** Wayne State University student, is the first Michigan medical student to receive the $1,500 Henry R. Viets Medical Student Fellowship awarded by the national Myasthenia Gravis Association. . . . The James D. Mills Meritorious Service Award was presented to **Judith Tintinalli, MD,** Detroit, from the American College of Emergency Physicians. The award is one of two presented annually by the ACEP to recognize excellence in emergency medicine. . . . Children's Hospital of Michigan president, **Robert H. Gregg, MD,** was elected chairman of the board of trustees of the National Association of Children's Hospitals and Related Institutions at its recent meeting. . . . Nine Iron County physicians have formed the Iron County Medical Education Corporation, a vehicle to provide financial aid and educational assistance to medical students, residents, PAs, and nursing students. The charter members of the corporation are: **Ray Koivunen, MD; Robert Han, MD; Michael Ivory, MD; Bruce Benkley, PA; Bayani Manzano, MD; Ronald Miller, MD; John Escott, MD; Daniel Powers, MD; Frederick Ludwig, MD.** . . . Sault Ste. Marie general surgeon **Earl Rhind, MD,** retired from his 46 years of practice last month. Doctor Rhind has been affiliated with the area's Polyclinic, War Memorial Hospital and the Emma Nason Home since 1943. . . . The American College of Chest Physicians awarded Honorary Fellowship to **Millicent W. Higgins, MD,** professor of epidemiology and director, program in general epidemiology at the U-M School of Public Health at Oct. 28 convocation ceremonies. . . . Seven abstracts of original investigations by Michigan physicians were accepted by the Scientific Program Committee of the American College of Chest Physicians for presentation at the ACCP's 47th Annual Scientific Assembly. Presenting authors of the abstracts are: **Agustin Arbulu, MD,** Wayne State University; **S. N. Ganguly, MD,** Wayne State University; **Andrew M. Hauser, MD,** William Beaumont Hospital, Royal Oak; **Joseph W. Lewis, Jr., MD,** Henry Ford Hospital, Detroit; **Donald J. Magilligan, Jr., MD,** Henry Ford Hospital; Hani N. Sabbah, BS, Henry Ford Hospital; **C. Zanetti, MD,** University of Michigan. . . . Noted Birmingham cardiologist **Arnold M. Weissler, MD,** has been appointed head of the cardiology sections at Harper-Grace Hospitals and Wayne State University School of Medicine. He is editor of a heart disease text and did much pioneering work in the development of noninvasive heart diagnostic procedures, and in fact, coined the term "noninvasive." . . . The International Precious Metals Institute has awarded its Henry J. Albert Distinguished Service Award to **Barnett Rosenberg, PhD,** Michigan State University, for his efforts in bringing cisplatin to its present state of development. Cisplatin is now used in the US and other countries as a cancer treatment . . . Sinai Hospital physicians will present **Maurice Tatelman, MD** with the Maimonides Award next month for his outstanding contributions to the cause of humanitarianism. The award is made on behalf of State of Israel Bonds, and recognizes Doctor Tatelman's long involvement in the field of radiology. . . . Retired Kalamazoo physician, **C. Allen Alexander, MD,** has sold to National Park Service officials the only known movie film of famed research scientist George Washington Carver. The 15-minute, color film has been kept in a bank vault since it was made in 1937.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

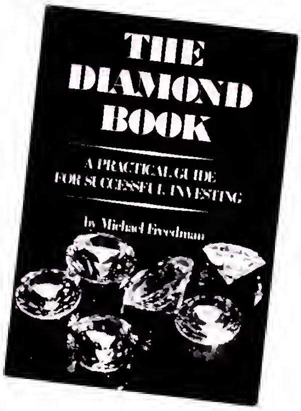
1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
143 Courtland Avenue
Rockford, Michigan 49341
(616) 866-9395

FREE! To physicians who want to learn about diamond investing — safely and with confidence.



To find out more about diamonds, which have appreciated faster than stocks, gold or silver, send in the coupon. After we meet, I will give you a free copy of this diamond reference book published by Dow Jones-Irwin. It retails for $14.95, but it's yours free in return for your time and interest in meeting with me. CALL (313) 569-2039

ROBERT MONDOR, NATIONAL CONSULTANT
The Diamond Trading Group
24001 Southfield Rd., Southfield, MI 48075

Tape or glue this Post-Paid Label to any envelope and mail your completed coupon to us. We pay the postage!

No postage necessary if mailed in the United States

BUSINESS REPLY LABEL
First Class Permit No. 315 Southfield, MI

POSTAGE WILL BE PAID BY ADDRESSEE
Robert Mondor, National Consultant
The Diamond Trading Group
24001 Southfield Rd.
Southfield, MI 48075

☐ Yes. I'd like to know more about your new diamond investment program. Please call me for an appointment and reserve my free copy of "The Diamond Book".
I understand there is no obligation.

Name (please print)

Address

City State Zip

Home Phone No. Business Phone No.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

DATE: Saturdays, 8:30 am to 11:30 am, Sept.-June. Orthopedic Conference. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Education. **Contact:** Dr. E. Guise (313) 876-2188. Approved for: 3 hours of Category I Credit.

Date: Wednesdays, 7:00 am to 10:00 am, Jan.-Dec. Emergency Medicine Conference Series. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Edacation. **Contact:** Dr. James Nowakowski (313) 876-1552. Approved for 3 hours of Category I Credit.

Date: December 3-4, The Second Annual Bronson Trauma Days on "The Critically Injured Patient — A Challenge to Care". Location: Kalamazoo Valley Community College, Kalamazoo. **Co-Sponsor:** Bronson Methodist Hospital Trauma Center, SWM Systems, Inc. and Southwestern Michigan Area Health Education Center. **For:** Trauma & Emergency. **Cost:** $50 - physicians; $40.00 - nurses; $20.00 - EMT. **Contact:** Sandy Vose, Program Assistant, Bronson Trauma & Emergency Center, 252 E. Lovell, Kalamazoo, MI 49007, (616) 383-7576. **Approved for:** 13 hours of Category I Credit.

Date: Dec. 12, Michigan Society of Pathologists December Seminar. Location: Rackham Amphitheater, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **Contact:** Willys F. Mueller, MD, Department of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours Category I Credit.

Date: December 14-18, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine in conjunction with the North American Academy of Manipulative Medicine. **For:** interested DOs and MDs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM; 517/353-8822. **Approved for:** 40 hours of Category I Credit.

Date: February 13, "Cytologic Manifestations of Repair." Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Willys F. Mueller, MD, Department of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 15-19, Emergency Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **For:** Emergency physicians, other physicians involved in emergency care, and nurses and other interested associated health professionals. **Cost:** $395 Practicing Physician; $225 Physician-in-Training; $225 Allied Health Professional; $150 Students. **Contact:** Wendy L. Frisch, promotion coordinator, Towsley Center for Continuing Medical Education, Department of Postgraduate Medical and Health Professions Education, University of Michigan Medical School, Ann Arbor 48109. **Approved for:** 36 hours of Category I Credit; 36 ACEP Credit Hours.

Thanks to our advertisers

Ad Council	600
Advance Medical Research	617
Brown Pharmaceutical	583
Burroughs Wellcome	587
Carlton Lush Investment	608
CBC Laboratories	607
Detroit Bank & Trust	585
Diamond Trading Group	633
Eli Lilly	597
Health Administration Press	612
I. C. System	611
Insight at Colombiere	614
International Diamond	623
S. H. Kaplan	596
Lightcom	609
Medical Protective	633
Merrell Dow	602
Michigan Bell	595
Michigan Physicians Mutual Liability Company	629
MSMS Committee to Assist Impaired Physicians	628
National Medical Enterprises	578
Physicians Insurance Co. of Mich.	605
Raleigh Hills Hospital	631
Reed Office Systems	612
Roche	576,577,578,600,601
E. H. Rowley	634
Smith, Kline & French	599
Stratton-Cheeseman	613
Troy Biologicals	618
University Microfilms	596
U.S. Air Force	617
Watkins, Ross, Baines and Lamps	62
Wyeth	589,59

E. H. ROWLEY COMPANY, INC.
Orthopedic & Prosthetic Appliances

A. Artificial Limbs
B. Commodes
C. Driving Controls
D. Breast Protheses
E. Hospital Beds
F. Lifts
G. Ostomy Supplies
H. Van Lifts
I. Pulsating Mattresses
J. Surgical Garments
K. Trapeze Bars
L. Walkers
M. Wheelchairs
N. Whirlpool Baths
O. Nerve Stimulators
P. Wheelchair Ramps

Please send more information about the circled items:

A B C D E F G H I J K L M N O P

Name ____________________
Address ____________________
City ____________________
State ______________ Zip ________

Tape or glue this Post-Paid Label to any envelope and mail your completed coupon to us. We pay the postage!

No postage necessary if mailed in the United States

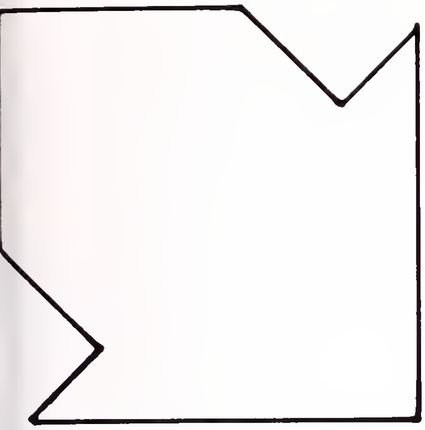
BUSINESS REPLY LABEL
First Class Permit No. 9, Royal Oak, MI

POSTAGE WILL BE PAID BY ADDRESSEE

E.H. Rowley Company, Inc.
317 E. Fourth Street
Royal Oak, MI 48067

E. H. ROWLEY COMPANY, INC.
317 E. Fourth St., Royal Oak, MI 48067 Phone: 544-3636
11330 Woodward Ave., Detroit, MI 48202 Phone: 868-6545
G1232 North Ballenger Rd., Flint, MI 48504 Phone: 235-1981
Serving the Handicapped Since 1908

NEW MEMBERS



Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

M. Rida Al-Ansari, MD U
8200 Jefferson #407
Detroit, 48214

Syed Shah Ali Akbar, MD IM/NEP
2056 Columbia Drive
Troy, 48084

Carol L. Anderson, MD OPH
1613 Sycamore
Royal Oak, 48073

Ricardo B. Barboza, MD DR
18251 Wiltshire
Lathrup Village, 48076

Roberta W. Beer, MD AN
5305 Huron River Dr. #3B34
Ypsilanti, 48197

David L. Bouwman, MD GS
4201 St. Antoine
Detroit, 48201

Eriberto Carrion, MD FP
P.O. Box 248
Bloomingdale, 49026

Michael D. Ciaramitaro, MD IM
9401 Hubbard Dr.
Dearborn, 48126

hyam S. Dandamudi, MD IM
03 Mulholland
Bay City, 48706

Douglas A. Devens, MD IM
13 W. McKay
aline, 48176

Bryan J. Dunlop, MD AN
6172 Indianwood Trail
Birmingham, 48010

Cynthia L. Fisher, MD FP
19959 Roslyn
Detroit, 48221

David Z. Gadzinski, MD FP
121 E. Ludington Ave.
Ludington, 49431

Michael J. Galvin, MD PD
1675 Leahy St. #250
Muskegon, 49443

Michael L. Gambel, MD FP
1118 Linden
Dearborn, 48124

Stanley J. Gerrick, Jr., MD GS
6114 Blvd. of Corners Four
Grand Blanc, 48439

Marvin L. Gibbs, MD OBG
2401 20th St.
Detroit, 48216

Henry P. Hammersmith, MD EM/R
12070 Hoskins
Cedar Springs, 49319

Michael R. Hournai, MD IM/NEP
405 W. Greenlawn
Lansing, 48910

Joslyn M. Hubacher, DO FP
121 E. Ludington
Ludington, 49431

Syed L. Husain-Hamzavi, MD D/IM
2040 W. Spinningwheel Lane
Bloomfield Hills, 48013

Parmanand Khandelwal, MD IM
1222 Vincent #16
Flint, 48503

Samuel J. Lacina, MD PD/PDC
833 Lake Dr., SE
Grand Rapids, 49506

Doo Sup Lah, MD PD
4672 Hill St.
Cass City, 48726

Deborah L. Lane, MD OBG
1322 E. Michigan #318
Lansing, 48912

Paul F. Lobert, MD PTH
1700 Clinton-Hackley Hosp.
Muskegon, 49443

Dante S. Loo, MD IM/N
Caro Community Hosp.
Caro, 48723

Abdol B. Maleki, MD IM
1575 W. Big Beaver
Troy, 48084

A. Colin McKinley, MD AN
5305 Huron River Dr. #3B34
Ypsilanti, 48197

F. Bruce Monroe, MD GS
P.O. Box 132
Allen Park, 48101

Jacqueline P. Moore, MD PED/HEM
15801 W. McNichols
Detroit, 48235

Dale K. Morgan, MD FP
403 Phoenix St.
South Haven, 49090

Luis F. Mosquera, MD GS
115 N. Lake St.
Manistique, 49854

David B. Munro, MD FP
740 W. Michigan Ave.
Jackson, 49201

Manouchehr Nikpour, MD NS
43241 Commons Dr.
Mt. Clemens, 48044

Leon D. Oostendorp, MD GS
21 Michigan St., NE
Grand Rapids, 49503

Vrajmohan Parikh, MD IM/CD
1201 Stone St.
Port Huron, 48060

Hester S. Pernell, MD IM
18595 Grand River
Detroit, 48223

Rajagopalar Rajaraman, MD OTO
24555 Haig
Taylor, 48180

John M. Ratchford, MD IM
1675 Leahy St.
Muskegon, 49443

Valluru C. Reddy, MD IM
503 Mulholland
Bay City, 48706

John E. Russo, MD GP
405 W. Greenlawn #300
Lansing, 48910

Subhash C. Sabharwal, MD IM/CD
22692 Ponchartrain Dr.
Southfield, 48034

Joseph Salama, MD ORS
15901 W. Nine Mile Rd. #700
Southfield, 48075

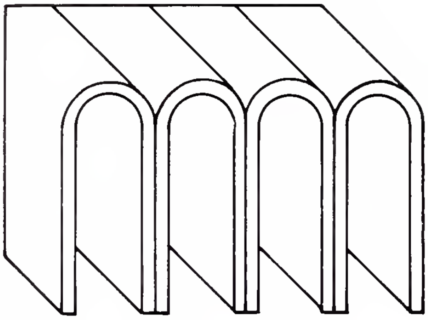
Geralyn M. Sarti, MD FP
2402 Pierce
Flint, 48503

Hernan S. Schmidt, MD P
131 E. Columbia Ave.
Battle Creek, 49015

George H. Shade, Jr., MD OBG
3040 E. Seven Mile Rd.
Detroit, 48234

Continued on page 636

DEATHS



Hubert M. Allen, MD
Birmingham

Hubert M. Allen, MD, Birmingham, died Oct. 4 at the age of 46. He received his medical education at the University of Michigan and Wayne State University's College of Medicine, then completed a residency at Ford Hospital. Doctor Allen became an associate surgeon on the hospital staff in 1970, and served as a clinical assistant professor of surgery at the U-M Medical School. He was certified by the Michigan and American boards of surgery. Doctor Allen was a retired lieutenant commander in the US Navy, and received a National Defense Medal and Vietnam Service Medal.

Lawrence A. Berg, MD
Sturgis

Lawrence A. Berg, MD, Sturgis, died Sept. 24. He was 74. Doctor Berg earned his MD degree in 1932 from the University of Michigan. After spending a year in private practice and two years with the Lansing City Health Department, he returned to U-M where he received his master's degree in public health. He completed advanced medical studies at Harvard School of Public Health. Doctor Berg served as the first director of the St. Joseph County Health Department, after having organized the Menominee County Health Department. A member of the Sturgis hospital staff, Doctor Berg opened his ophthalmology office in Sturgis in 1946, following four years of WWII service as a Navy medical officer.

Henry A. Doorn, MD
Grand Rapids

Henry A. Doorn, MD, Grand Rapids, died Sept. 6. He was 75. Doctor Doorn maintained an otolaryngology and general practice until his retirement in 1976. He received his AB degree from the University of Michigan in 1944, and his MD and HMD degrees from Hahnemann Medical College of Philadelphia in 1948.

Rex R. Harrington, MD
Ironwood

Rex R. Harrington, MD, Ironwood, died August 24 at the age of 61. He received his doctor of medicine degree at the University of Iowa in 1944, and served in the Army Medical Corps in the U.S. and Germany from 1946 until 1948. He started his Ironwood practice in 1949 and was chief of staff at Grand View Hospital for many years. Doctor Harrington also taught emergency medical technician classes at Gogebic Community College.

Glen E. Hause, MD
Southfield

Glen E. Hause, MD, Southfield, died Sept. 29. He was 73. Doctor Hause was a pediatrician for 44 years in the Detroit area and served as chairman of pediatrics for Mt. Carmel Mercy Hospital in Detroit from 1939 until 1964. He received his MD degree from the University of Michigan in 1932. Doctor Hause was a diplomate of the American Board of Pediatrics, a member of the American Academy of Pediatrics, and the Detroit Pediatric Society.

Charles B. Lakoff, MD
Detroit

Charles B. Lakoff, MD, Detroit, died August 30 at the age of 87. He earned his doctor of medicine degree from the Indiana University School of Medicine in 1920. Doctor Lakoff, a member of the American College of Surgeons, retired two years ago.

Grant L. Otis, MD
Jackson

Grant L. Otis, MD, Jackson, died Sept. 20 at the age of 75. He retired in 1977 after 40 years of practice in Jackson. Doctor Otis was an internist specializing in cardiology. He was medical director of Jackson County Civil Defense from 1952-1965 and was a member of the state's Civil Defense Advisory Council from 1963-1969. Doctor Otis also served on the Foote Memorial Hospital board of trustees from 1971 until his retirement, and was chief of staff in 1947-48. After his retirement, he worked with the Professional Standard Review Organization. A medical corps executive during WWII, Doctor Otis earned his medical degree from the Harvard Medical School in 1934.

Robert A. Willits, MD
Elkton

Robert A. Willits, MD, Elkton, died August 17. He was 48. He received his MD degree in 1957 from Case Western Reserve Medical School, then interned at Midland Community Hospital. Doctor Willits began his Elkton surgical practice in 1958, then later joined the medical staff at Pigeon Clinic and Scheurer Hospital, serving until his retirement in 1978.

NEW MEMBERS/*Continued*

Elisea N. Singson, MD NEP/IM
1198 Westwood Dr.
Flint, 48504

Louis V. Spielman, MD AN
1060 W. Norton Ave.
Muskegon, 49441

Sarveswararao Talla, MD PD
20180 W. 12 Mile Rd.
Southfield, 48076

James S. Tashjian, MD I
4572 Walden Drive
Birmingham, 48010

Thomas M. Teal, MD FI
148 N. Saginaw St.
Chesaning, 48616

Paul C. Turner, MD IM
678 Front St., NW
Grand Rapids, 49504

Sumer D. Verma, MD I
401 W. Greenlawn
Lansing, 48910

Craig A. Wheeler, MD IM
17800 E. Eight Mile Rd. #632
Harper Woods, 48225

David H. Wiedemer, MD GE/IM
241 E. Saginaw #610
East Lansing, 48823

Timothy R. Woltanski, MD FI
202 N. Thomas St.
Scottville, 49454

No Yk Yun, MD PTI
6232 Hospital Drive
Cass City, 48726

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions open

MEDICAL DIRECTOR (Part time) — Michigan licensed physician to act as medical liaison for PSRO activities involving approximately 15 hours per week. Utilization review experience preferred. Reply, with resume, to Michigan Area II PSRO, 1305 E. Eighth St., Traverse City, MI 49684.

WANTED: Residency-trained family physician to join young solo f.p. in pleasant small college town to provide "whole person care from the Christian perspective." Frederick L. Bean, MD, 122 S. Howell, Hillsdale, MI 49242, (517) 439-1565 (office) or (517) 439-1908 (home).

Child Psychiatrist or General Psychiatrist experienced with children and adolescents to join a multidiscipline professional group providing comprehensive outpatient services. Good opportunity to establish dynamic and rewarding private practice. Contact P.P. Medrano, MD, 32910 W. Thirteen Mile Road, Farmington Hills, 48018. Telephone 313/626-8811.

Second Obstetrician and General Surgeon wanted by 11 man multispecialty group in Northeastern Wisconsin. Reply to Gerard DeBruin, Business Manager, Boren Clinic, 1510 Main Street, Marinette, Wisconsin 54143.

PSYCHIATRIST — Full time staff psychiatrist position available in the Outpatient Mental Health Clinic. Responsibilities include outpatient treatment and student teaching. This is a 458 bed acute care facility located in suburban Detroit. Board certification preferred. Approximate salary range: low to mid-fifties. Liberal benefits offered. Send vitae to M. Roberts, MD, Director, Mental Health Service, Providence Hospital, 16001 W. Nine Mile Road, PO Box 2043, Southfield, Michigan 48037.

EIGHT MAN MULTI-SPECIALITY GROUP consisting of five family physicians seeking a board certified or board eligible Family Physician with a desire for obstetrics to join professional corporation serving a drawing population of 45,000. 200 bed hospital one mile from clinic. Excellent salary, variety of fringe benefits, and opportunity to become a partner after one year. Alpena located in Northern Michigan on a bay of Lake Huron and rates very high in outdoor recreation. Please send inquiries and C. V. to Barbara Barkley, Medical Arts Clinic, P.C., 211 Long Rapids Road, Alpena, MI 49707.

ARIZONA EMERGENCY MEDICINE: Directorship and clinical positions available for career-oriented emergency physicians in sunny western Arizona resort town. Excellent income, paid professional liability insurance, and flexible scheduling without on-call duties. For details call Lillian Asato toll-free, 1-800-421-6655; or send credentials in confidence to 606 Wilshire Boulevard, Suite 504, Santa Monica, CA 90401.

EMERGENCY MEDICAL POSITIONS — Emergency Consultants, Inc. has Emergency Medicine opportunities available in resort and metropolitan locations. 60 hospitals in 12 states are currently serviced. Benefits include competitive salaries, paid malpractice insurance, and flexible scheduling. For further information contact: Emergency Consultants, Inc., 2240 South Airport Road, Suite 115, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OPHTHALMOLOGIST WANTED to do office ophthalmology two or three days a week in well-equipped suburban office outside of Detroit. Excellent terms. Reply to Box 19, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

CALIFORNIA-DIRECTOR POSITIONS AVAILABLE. Emergency medicine physicians needed for rural Northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit-sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610. 415/832-6400.

PART-TIME PHYSICIAN needed to do routine physicals to assess donor suitability for plasmapheresis. Good position for older physician looking to slow down. Malpractice coverage provided. Contact Thomas Anderson at American Plasma Management, Kalamazoo, MI. Phone 616/381-0086.

OPHTHALMOLOGIST FULL-TIME, outstanding opportunity to join busy practice in suburb of Detroit. Reply to Box 20, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

Positions with The State Of Michigan — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background. Office locations in Southfield, Lansing, and Traverse City. Also considering an office in Kalamazoo. Salary in 50's with approximately 40% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant (517) 373-7830. In Michigan, call toll free 1-800-292-2710.

Miscellaneous

HOLTER MONITOR Scanning Service. High Quality, prompt service. First cassette free. Call for information and free mailers. DCG Interpretation, 313/879-8860.

OFFICE PLANNING & DESIGN of the spaces and the systems which allow a medical practice to thrive. PSCrawford Associates offers professional assistance in developing programs for work flow and space utilization which incorporate efficient, humanistic design ambiance. Our services are structured to take your project from initial planning through completed installation. For a free Facilities Planning Checklist to aid you in defining your design needs call Pam Crawford at 313/665-5742 or write PSCrawford Associates, 116 E. Liberty, Ann Arbor 48104.

FOR SALE: Viagraph II Stress EKG testing unit, with treadmill. Contact Mr. Dlugokinski, of Flint Family Practice at 313-235-9803.

32 Bed Adult Foster Care and special programmed facility. 12 staff members includes one O.T. Located in Southeast Michigan. Priced at $2,500,000 with excellent terms at 9%. Building is constructed of concrete and steel. Call George Wisner, 313/635-7617, LaNoble Realty Business Brokers, 1516 E. Michigan, Lansing. Home, 517/482-1637.

CHARTER FISHING on a gorgeous 36′ boat on Lake Michigan with a licensed captain next summer in exchange for 1-2 weeks in your residence in Florida this Feb. or March. Keys preferred, but all areas considered. Contact Dr. Cook, 3255 S. Lakeshore, Ludington, 49431, or call 616/845-7620.

ON BEAUTIFUL AUSABLE RIVER (Main stream 195 ft. frontage, 3.6 acres). Prime trout fishing out your front door. Well insulated year around retreat. Wood stove plus brick fireplace. 4 bedrooms, two baths. Garage. 5 miles east of Grayling. $89,900 — Terms — #335, ask for Ruth. Century 21 River Country Grayling. (517) 348-5474 or (517) 348-9868.

For Sale or Lease Option. Beautiful three bedroom, den, family room, two bath home in professional neighborhood of East Lansing. New carpeting and all appliances. Available immediately. Contact Dr. John Meade, 526 Townsend, Lansing. 517/485-7181.

BATTLE CREEK, Michigan — 4300 square foot Medical-Dental facility. Available in October or November, 1981. Located within two minutes drive of two LARGE HOSPITALS. Country setting with abundant parking. Attractively designed and landscaped. Call Ron Kuhn, 616-968-5200 days, 616-979-1810 evenings.

WE HAVE VARIOUS QUANTITIES OF MEDICAL EQUIPMENT available in excellent condition. We buy, sell, trade, move and repair. New equipment also available. Call Doctor Medical Resale, (313) 569-4407, 9 a.m. to 9 p.m.

OFFICE FURNITURE. Superb designer's selection. Custom-to-order from solid teak, rosewood, mahogany and walnut. Catalog on request. Detroit Woodworking Co., telephone: 313/832-6721.

SANDRA W. COCHRAN, MEDICAL ILLUSTRATOR. Medical illustration available, from detailed realistic renderings to simple diagrams, graphic design and biophotography. For quality illustrations at the lowest cost, call (313) 652-2547, or write 1163 Ironwood Court, Apt. 104, Rochester, Michigan 48063.

FOR SALE: all brick 4 bedroom, 2 bath home, beautiful private location, 2½ acres, attached 2 car garage, basement rec room with fireplace, patio, gas furnace, central air, 330 ft. frontage on Raisin River, spring fed lake, swim — fish, good schools, 8 minutes to good local hospital, approx. 30 miles to Ann Arbor. Terms: land contract. Write C. Trickey, 9431 Tonneberger, Tecumseh, 49286.

HILTON HEAD ISLAND, SC. Ocean Villa, Captain's Cove in Palmetto Dunes Resort. Luxurious new villa, 150 yds from beach. Lagoon backyard, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, pool, fishing, canoeing, biking, etc. Weekly, monthly. Call or write, (313) 695-0356, 6236 Kings Crown Rd., Grand Blanc, MI 48439.

MEDICO-LEGAL

State Bar members no longer taking organization for granted

By A. Stewart Kerr
Detroit

Michigan lawyers are required to belong to the State Bar of Michigan. They are subject to its disciplinary control, under the aegis of the Michigan Supreme Court. Failure to pay State Bar dues results in loss of license. The State Bar has, like many trade associations, many inactive members who may well feel that they are not interested in State Bar activities and that the State Bar holds nothing for them.

In 1979 a Michigan lawyer brought an action in the Supreme Court against the State Bar of Michigan asking that he be relieved from paying that part of his State Bar dues relating to State Bar activities which he believed to be "unlawful and unconstitutional." On April 21, 1981, the Supreme Court's per curiam decision was that there was not a court majority for a dispositive decision and an evidentiary hearing will be held concerning relevancy of such activities as: Young Lawyers Section; Lawyers Wives of Michigan; Lawyer Placement Service; commercial sale of the mailing list; and, especially, activities to influence legislation.

Three justices held that the state may exact compulsory dues to support only those duties and functions which serve a compelling state interest and which cannot be accomplished by less intrusive means upon the First Amendment rights of the objecting individual(s). These three judges opined that such things as legislative and lobbying activities and activities designed solely to further commercial interests of the members are impermissible.

Two other justices concluded that the various State Bar activities are permissible and that the only relief that the complaining attorney should have would be to remove his name from the roster sold for commercial use.

Two other justices concluded that the record was sufficient to resolve some of these issues but not others and that the cause should be remanded for a further hearing. Their opinion seemed to be that more data are needed in the record concerning: Lawyer Placement Service; commercial sale of the mailing list; activities addressed to influencing legislation and certain activities beyond those directly educating members of the Bar and the public about the law and the legal system.

Additional evidence will be accumulated by hearing and the matter will again be before the Supreme Court. Whatever its outcome, the winds of change are blowing. The so-called integrated Bar, long the envy of some physicians, may have at least peaked out in its powers.

Here is an interesting sidelight for those physicians who may doubt the necessity for and values of a professional trade association: Some concerned lawyers across the state, fearing the final result of this integrated bar litigation, already are talking seriously about the formation of a second, purely voluntary bar association. This is so that the profession may carry on with those activities and programs which some have heretofore taken for granted and others felt they didn't need — at least up until the time that they found these things in jeopardy!

Mr. Kerr is MSMS legal counsel.

MICHIGAN MEDICINE

December 1981 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 80, Number 35

MDS

OF THE
PHYSICIANS
HIA
JAN 5

MSMS programs, member benefits

Who to call at MSMS headquarters

Advertising (in *Michigan Medicine*)	Sheri Greenhoe
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting	
Program	Sherry Fent
Meeting Facilities	Marce Ireland
Arbitration	Bill Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Marce Ireland
MSMS-Sponsored Conferences	Sherry Fent
Cost Containment Programs	Debbie Zannoth
Dues Payments	Peg Berry
Financial Operations	Dick Campau
Foreign Medical Graduates	Mert Scholten
Health Career Information	Mert Scholten
HMOs (Health Maintenance Organizations)	John Richards
Health Planning	Dennis Paradis
Impaired Physicians	Marcelyn Ireland
Jail Health Project	Dick Campau
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose Ellen Vinocur Potash
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
Medical Assistants	Caroline Rich
Medical Auxiliary	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medigram	Judy Marr
Meeting Information (National, State)	Sheri Greenhoe
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Vi Heins
Michigan Doctors Political Action Committee	Kevin Kelly
Michigan Medicine (MSMS Journal)	Judy Marr
Michigan Society of Anesthesiologists	Caroline Rich
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
Meeting Facilities	Marce Ireland
MSMS News Relations	Mert Scholten
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Wayne Burmeister
MSMS Travel Programs	Marce Ireland
Physician Hospital Relations	Bill Madigan
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	Bill Madigan
PSRO	Sherry Wellman
Specialty Societies	
Information	Nancy Wimmer
Committee of Specialty Society Presidents	
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society
120 West Saginaw (Box 950)
East Lansing, MI 48823

MSMS PHONE: 517/337-1351

MICHIGAN
MEDICINE
MSMS programs, member benefits

MSMS itself is the subject of this month's special report, and, really, of the entire issue. A wintertime photo of MSMS headquarters highlights this month's cover. **(Photo by Mert Scholten)**

MICHIGAN MEDICINE

December 1981, Volume 80, No. 35

Special report

645 MSMS headquarters — the building itself — is 20 years old this year. *Michigan Medicine* recounts some delightful details of those days in 1959, 1960 and 1961 when MSMS operations were moved from an old mansion in downtown Lansing to the present site. In addition, this month's special report describes brand-new MSMS efforts to gain student and resident members, and to provide more valuable services for MSMS members; Barbara Wertz, Mert Scholten and John Anthony

Features

641 MSMS officers and Council members

656 Executives and officers of MSMS component societies

660 MSMS Public Affairs/Leadership Conference arms physician leaders for coming economic times; Judith Marr

664 Finances: Which retirement plan for you?

665 Purposes and members of MSMS committees

Departments

640 In my opinion; Harvey M. Andre, MD

649 New members

652 News; Sheri W. Greenhoe

680 Meetings

Ad index

681 Classified ads

682 President's page; James D. Fryfogle, MD

Many features in this issue combine to make it a useful reference for MSMS members. Among them are the lists of MSMS officers and councilors, of MSMS committee chairmen and members, of component society executives and officers. Most important features are the special inserts — "MSMS at Work," the descriptive brochure of MSMS programs and activities, and the special tear-out on MSMS insurance program benefits.

This issue's a "keeper" — and we hope members will share it with their colleagues who have not yet decided to join organized medicine.

IN MY OPINION

Your ideas may become national medical policy

By Harvey M. Andre, MD
Grand Rapids

You are an important national medical personage! You may not think so, but you are!

That is true because of the way our county and state medical societies, and the AMA, are organized. No other medical organization is so constituted that a single individual's ideas or ideals can become a part of state or national policy for the betterment of the entire medical profession.

Let us see how this works.

Suppose you have an idea to improve medical care or public safety, or perhaps to better protect medicine from government interference, decrease medical malpractice claims, or curb inroads by non-medical professionals.

You talk the idea over with other doctors, get your basic facts and opinions boiled down to clear, concise statements and research statistics to confirm your premises.

You then present them to your county society delegates, or to the entire county society at one of its meetings.

Your ideas will then be incorporated in the form of a resolution.

County society members may modify the resolution to more clearly state your idea and avoid conflicts with MSMS and AMA policy. Or, the resolution may seek to change the MSMS or AMA policy.

Resolutions must be submitted at least 30 days prior to the spring meeting of the MSMS House of Delegates.

Resolutions are sent to reference committees at the first session of the House. Committees are appointed each year by the Speaker of the House, and consist of seven delegates from various areas of the state.

The reference committees consider each resolution separately, or several as a group, if they address the same problem. The delegate or alternate sponsoring the resolution is at the meeting to defend the premises of the resolution. Those who oppose the resolution are given an opportunity to argue against it.

After the resolutions have been thoroughly discussed, committees meet in executive session. When the reference committees report to the floor of the House, resolutions may be recommended for passage as presented, changed, or recommended for defeat. Each resolution, or combination of similar resolutions, may be accepted and passed by a majority vote, as the resolution was presented by the reference committee, rejected in toto, or amended. At times a substitute resolution recommended by the reference committee may be rejected, and the resolution as originally presented may be accepted and passed by the House of Delegates.

If a resolution affects national policy of the medical profession, one of the "resolves" may refer it to the Michigan delegation to the AMA. The delegation is instructed to introduce the resolution in its final wording to the AMA House of Delegates. It will then be considered and acted upon by the same mechanism in the AMA House of Delegates, as in the MSMS House of Delegates. Believe me, *your idea* can become national policy of the AMA by this mechanism. Every one of the national policies, standards, promotion of or opposition to any issue or laws affecting the medical profession started out as an idea of one *individual*, and that one individual *can be you!*

Doctor Andre is an orthopedic surgeon, an MSMS councilor, and member of the MSMS Committee on Publications.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairm
Harvey Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
John R. Ylvisaker, MD, Pontiac

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $20.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, advertising, should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351.

©1981 Michigan State Medical Society.

MSMS leaders at the Oct. 21 MSMS Council meeting posed for a group portrait. In checked coat in front row is MSMS President James D. Fryfogle, MD, Southfield. To his left is MSMS Council Vice Chairman Carl A. Gagliardi, MD, and to Doctor Gagliardi's left is Council Chairman Thomas R. Berglund, MD. Others, from left, are Councilors Busharat Ahmad, MD; Frederick W. Bryant, MD; Richard L. Rapport, MD; Harvey M. Andre, MD; David Siegel, MD; Justin L. Sleight, MD; Dean P. Carron, MD; Kenneth J. Ray, MD; Robert E. Paxton, MD; William D. Walters, MD; MSMS Secretary Robert M. Leitch, MD; Councilor Kenneth B. Herrington, MD; MSMS Treasurer Leland E. Holly, II, MD; MSMS House of Delegates Vice Speaker Gerald H. Mandell, MD, and AMA delegation representative to the Council Donald K. Crandall, MD.

Michigan State Medical Society

President	**James D. Fryfogle, MD,** Southfield
President-Elect	James H. Tisdel, MD, Port Huron
Secretary	Robert M. Leitch, MD, Battle Creek
Treasurer	Leland E. Holly, II, MD, Muskegon
Speaker	David Siegel, MD, Lansing
Vice-Speaker	Gerald H. Mandell, MD, Detroit
Past President	John R. Ylvisaker, MD, Bloomfield Hills
AMA Delegation Rep.	Donald K. Crandall, MD, Muskegon

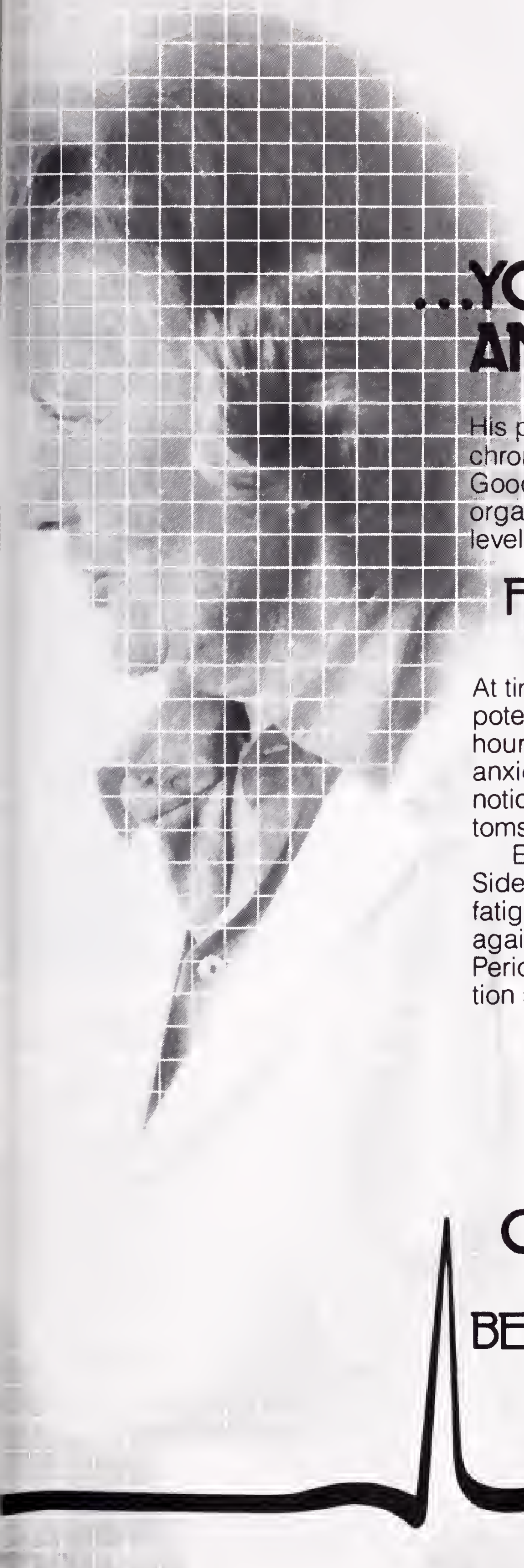
The Council

Chairman	**Thomas R. Berglund, MD,** Portage
Vice-Chairman	Carl A. Gagliardi, MD, Dearborn

Councilors

District 1	Carl A. Gagliardi, MD, Dearborn
	James J. Humes, MD, Detroit
	Marion G. McCall, Jr., MD, Detroit
	Kenneth J. Ray, MD, Trenton
	Arthur A. Ulmer, MD, Grosse Pointe Shores
	Frank B. Walker, MD, Grosse Pointe Farms
District 2	Justin L. Sleight, MD, Lansing
District 3	William D. Walters, MD, Battle Creek
District 4	Thomas R. Berglund, MD, Portage
District 5	Harvey M. Andre, MD, Grand Rapids
District 6	Richard L. Rapport, MD, Flint
District 7	Kenneth B. Herrington, MD, Bad Axe
District 8	Robert J. Toteff, MD, Saginaw
District 9	Vickers C. Hansen, MD, Manistee
District 10	Charles L. Oppy, MD, Roscommon
District 11	Robert E. Paxton, MD, Fremont
District 12	Busharat Ahmad, MD, Marquette
District 13	William S. Jones, Jr., MD, Menominee
District 14	Dean P. Carron, MD, Ann Arbor
District 15	Frederick W. Bryant, MD, Royal Oak
	Billy Ben Baumann, MD, Pontiac

THE PATIENT THINKS
HE HAS HEART TROUBLE...



...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® Ⓘⓥ

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

ROCHE®

Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10;* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701
†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

ROCHE®
ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

When we help establish your practice, your primary cares will be solved.

To establish a Primary Care practice, your first need is to solve your primary cares.

That's where we come in.

We can offer you a choice of over 60 well equipped acute care hospitals coast to coast. We can offer you selected financial assistance. We can offer you management consulting.

So whether you're interested in a solo, partnership, or group practice, contact NME today.

We'll help establish your practice.

And solve your primary cares.

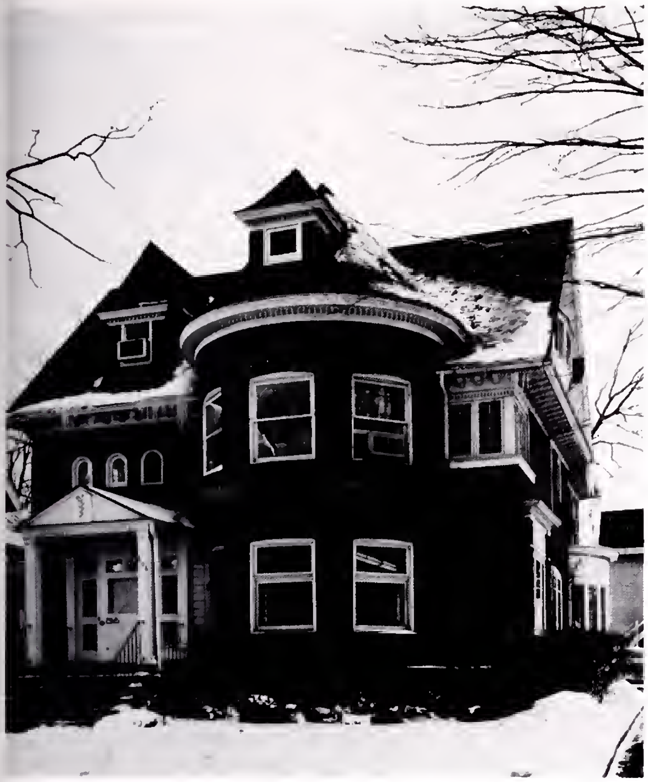
For further information, contact:
Raymond C. Pruitt, Director, Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.
Call Toll-Free 800-421-7470
or collect (213) 479-5526.

NATIONAL MEDICAL ENTERPRISES, INC. NME

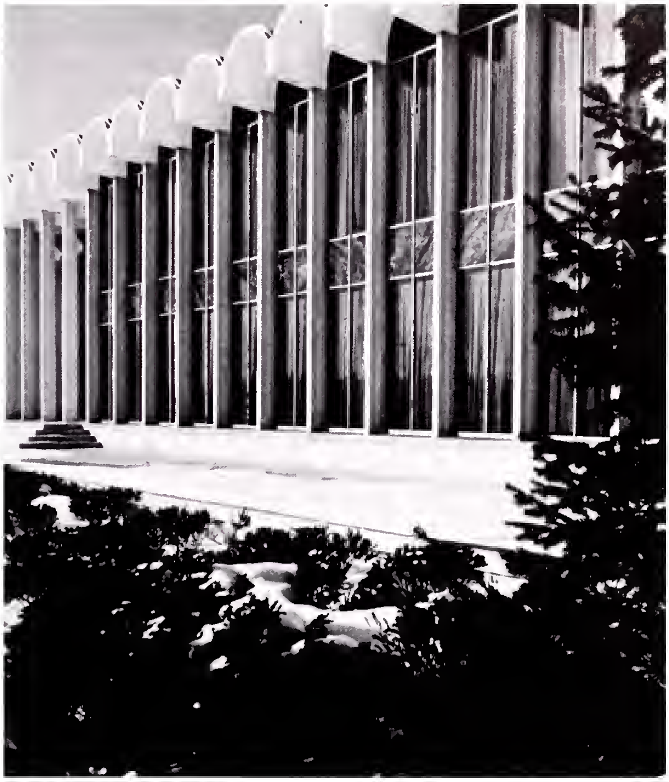
"The Total Health Care Company."
An Equal Opportunity Employer M/F

SPECIAL REPORT

Twenty years ago, MSMS headquarters changed from this . . .



to this . . .



do you remember?

By Barbara Wertz
East Lansing

At the time of the major change pictured above, the MSMS membership stood at approximately 6500. There were 20 persons on the MSMS staff.

The association was housed in the Kerns Mansion at 606 Townsend Street in Lansing (photo above).

It was a beautiful old building with a great deal of charm, but MSMS outgrew it in the few years there.

It seemed obvious to all in the late 1950's that the mansion was no longer able to meet the growing needs of the Society. The staff put up with files in spare trash cans, crowded working conditions, uncoordinated office furniture and no space for committee meetings. "We were filled to overflowing," recalls current MSMS Director Warren F. Tryloff. "We were even using the third floor attic, trying to make it habitable."

Because there was no room suitable for meetings at the MSMS headquarters, members travelled to various places about the state to meet. It was not uncommon for these trips to require an overnight stay, thus using a considerable portion of the doctor's precious time. And it was expensive.

The 'Big Look'

The need for additional space was a reality then, but some farsighted members were looking toward the needs of the future. Among them was William S. Jones, MD, the president of MSMS at the time. Doctor Jones was a man who saw the Society as having functions and duties beyond those it was already fulfilling.

"MSMS was nowhere near the functioning organization we have now," recollects Kenneth H. Johnson, MD, Lansing, then MSMS president-elect. He served as chairman of the site selection and building committees for the new MSMS headquarters.

"We had an organization on paper, we had meetings and debates, passed resolutions. But the service angle which has become so important in recent years had not been developed in any shape or manner.

"That was the real goal for those

Ms. Wertz is a free-lance writer.

of us acting on the organizational side. We felt that was the reason for branching out. We couldn't do that in the building we were in."

It was not all that clear in the beginning what MSMS was going to do, recalls Mr. Tryloff. "Our final concept came about in the process of designing the building," he says.

There was controversy over the new building. Many members felt that what was needed was a solely functional structure. They felt that because all that was needed was more work space, more "elbow room," anything might do. Suggested were the possibilities of buying houses adjacent to the present office or moving to a larger, already existing building.

Doctor Jones and some of his colleagues disagreed with this viewpoint. They felt that if it was time to make a move, then it was best to reassess the goals of MSMS and to plan ahead. They promoted the idea that this was the chance for MSMS to expand, to become more visible to the community and to the state as well as to MSMS members.

They felt that the most important facet of the Society was service, and by improving the physical surroundings and working conditions they would be better able to continue in that vein. In time, this viewpoint became the general consensus.

To get the ball rolling, the "Big Look" Committee was formed, with Doctor Jones as chairman. This group was suitably named, for there was a great deal of scouting around to be done before any decisions could be made. In addition to finding an appropriate place to build the new headquarters, an architect needed to be selected and a design chosen.

While Doctor Johnson headed the Site Committee to determine what the land possibilities were, others went to work on narrowing down the candidates to design the structure.

Beauty and practicality

Finally, the decision was made to employ Minoru Yamasaki, an up-and-coming young architect. Little did anyone know he would later design such famous buildings as the twin World Trade Towers in New York.

Based on ideas expressed by the committee, Yamasaki produced a creation which all found agreeable and impressive. The design combined both beauty and practicality with its well planned spaciousness. It called for marble, cement and glass to form arches resting atop vertical columns.

As attractive as this combination was to be, it was matched evenly by the functional aspect of the plan. Allowed for in the structure were large board rooms, offices, lounges, and even a dining facility to enable all types of events.

While all this was taking place, Doctor Johnson and his committee were hard at work whittling down the number of sites. They narrowed possibilities to 21, and an afternoon expedition was arranged so that a final selection might be made.

That task was accomplished when Mr. Yamasaki saw lot number 7 — the present location of the MSMS building. He was completely taken by the scores of trees which landscaped the area, and urged the committee to give it their consideration. They did, and construction began a short time afterwards.

As with any structure, there were a few trials and tribulations in the building of the new headquarters. For starters, orders had been given by Mr. Yamasaki that the bare minimum of trees be removed and the rest be protectively wrapped. This foresight is much to our delight today; but at the time, it made construction rather awkward.

In addition to that complication, some of the arches which had been precast in Detroit did not fit properly and required another pouring. Probably the most troublesome stumbling block was the discovery that there was an underground spring located below what was to be the parking lot, which explained the numerous trucks up to their axles in the mire.

Eventually, all the problems were ironed out and the building was completed and prepared for use. Lillian Pierce, a member of Yamasaki's staff, was asked to take charge of the decorating. Like Yamasaki, Ms. Pierce was concerned foremost with creating a functional environment set in an aesthetic atmosphere. She interviewed each member of the MSMS staff to determine their job duties and needs. The result was a modern design which allowed for easy movement and smooth operations.

A dream culminated

At last the staff moved in, and final arrangements made for the dedication ceremonies which were to take place over a period of three days.

"It was like the culmination of a dream for me," remembers Doctor Johnson. "Generally speaking, we all felt tremendous satisfaction. Everyone cooperated in going ahead with this thing.

"At the beginning we had a great deal of opposition, but within a year or two, everybody was completely convinced we had done the right thing."

On June 4, 1961, the formal opening ceremony took place. Speakers for the occasion included E. Vincent Askey, MD, president of the American Medical Association; Kenneth Johnson, MD, by then president of MSMS; and J. J. Lightbody, MD, speaker for the MSMS House of Delegates.

"We invited MSMS members, representatives of all the health organizations in Michigan, the press, and interested East Lansing professionals," says Warren F. Tryloff, current MSMS director. "It was a great group."

The MSMS headquarters building has undergone refurnishings and rearranging over the years.

It has been joined by the adjacent Cyrus Stockwell Building, built in 1979 and connected by a tunnel to the original MSMS edifice.

The Stockwell building harmonizes in colors and building materials with the Yamasaki-designed building, and houses the MSMS Physicians Service Group, Michigan Physicians Mutual Liability Company and other professional organizations.

But MSMS headquarters still functions as that for which it was originally designed — a means of better serving the physicians of the state.

MSMS wants you — residents and students!

By Mert Scholten
East Lansing

MSMS doesn't have a poster of a bearded uncle pointing his finger. But the message is certainly the same as the MSMS Committee on Membership Recruitment and Retention opens its campaign to enlist student and resident members.

"We need to recruit as many residents and students as possible," says Committee Chairman Billy Ben Baumann, MD. "They are the future blood of this organization."

MSMS currently has less than 40 residents who are members and only a handful of student members.

"On the other hand, the AMA, which recruits residents directly, has some 900 resident members in Michigan," notes Doctor Baumann. "It's a case where someone is at least doing the asking. MSMS in the past has simply not bothered asking."

Membership on merits

The Membership Committee is out to change that.

MSMS President James D. Fryfogle, MD spoke to students at Wayne State University Medical School freshman orientation. MSMS staff and existing student members made membership pitches at both the U-M and MSU freshman orientation sessions. About 15 student memberships are in process as an outgrowth of these contacts.

Plans are underway to hold simple social gatherings at each of the medical school campuses. Organized by student leaders with MSMS support, these meetings will provide an opportunity for MSMS to present itself to the students.

In addition to offering students and residents a more active voice in MSMS through the bylaws amendments adopted by the 1981 House of Delegates, MSMS is in the process of investigating insurance and other benefit possibilities with appeal to both students and residents.

"But we have to sell membership on its own merits," emphasizes Doctor Baumann. "All the benefits in the world will not attract members until they perceive the organization as active and meaningful."

The big task facing the committee and every MSMS member is to emphasize the positive side of belonging to the mainstream of organized medicine, Doctor Baumann notes. "I know it sounds trite, but if MSMS were not here to speak for doctors, who would?"

The membership committee recognizes that not every doctor will join organized medicine on the basis of simple flag waving or from a sense of professional duty. "We have to develop multiple approaches to membership recruitment of students and residents as well as practicing physicians, realizing that what turns one person on to membership may turn another off."

MSMS is setting up a series of meetings through hospitals which offer residency training.

"We simply want to invite the residents to join us for a bit of refreshment and an opportunity to talk about medicine and its future direction," says Doctor Baumann in describing the planned gatherings.

"We know the reason many young physicians do not join our ranks sooner is because they simply have never been asked. These gatherings will be our chance to invite them to be part of us."

The goal of the committee is to add 200 students and 200 residents to the MSMS membership rolls during the coming year.

"To meet this goal, though, we need the help of every MSMS member; the job cannot be done by the committee or staff alone," says Doctor Baumann.

Challenging every member who believes in organized medicine to be a part of its continuation, Doctor Baumann points out two things which existing members can do:

1. Encourage colleagues, students and residents to join the county society, MSMS and the AMA. All any of these potential members need is an invitation.

2. Let MSMS know of opportunities to meet with residents and students. If MSMS members teaching responsibilities or preceptorship opportunities will let MSMS know in advance about group meetings, MSMS will supply materials, speakers or assistance to tell medicine's story.

"With all of the problems facing medicine now and in the future in terms of numbers, practice styles, competition, government regulation, etc., there is a greater need than ever to work collectively," concludes Doctor Baumann.

"It's a cinch that if doctors themselves do not confront these challenges on our own behalf, no one else is going to do it for us. They will work for their own ends and not for the collective good of organized medicine."

Mr. Scholten is MSMS Chief of Communications.

MSMS physician service group expanding, refining programs

By John Anthony
East Lansing

Physician
Service
Group, Inc.

The Physician Service Group is a member service subsidiary of the Michigan State Medical Society.

The PSG continues to expand and refine its efforts to provide quality services and products to MSMS members. In addition, a major objective of PSG is to increase the economic well being of Michigan physicians. This includes both their business practice and their personal financial situations.

PSG criteria

The PSG's objective is to aid the physician by making available tools and resources otherwise not available, too expensive, or of dubious quality. The PSG can assure this availability, reasonable cost and constant quality.

Practice Management

A major activity of the PSG is to conduct practice management consultations and seminars. A large number of individual consultations have been done during the last year and the results have been quite good. The physicians are usually very satisfied with the advice they receive and attempt to incorporate the changes suggested.

The PSG soon will expand the numbers of practice management seminars to reach more physicians. A curriculum has been developed for residents who are about to establish themselves in practice.

During the last year over 16 of these seminars have been conducted for residents throughout the state. The course material is now being developed for practicing physician's seminars on financial controls in their office, personnel and on computer usage. These seminars will be conducted by the PSG staff and a cadre of outside consultants available to speak.

Collections service

The PSG endorses the I.C. Systems Collection Compaay for use by physicians in collecting indebted accounts. Since the PSG endorsement of I.C. Systems in 1980, the company has collected over $3,000,000 for Michigan physicians. There currently are over 2,000 physicians' offices using this program. The cost to the physician is substantially below other collection companies' charges.

Credit Cards

The MSMS/PSG Credit Card program has run successfully for over a year now, and the physicians who use this service seem quite satisfied. The way the system works is that physicians allow their patients to use credit cards to make payments for services rendered by the physician.

In turn the physician's office sends the information on the sales draft to the PSG office, PSG deposits these amounts immediately, and each two weeks sends the physician a check for the appropriate amount, less a small administrative charge.

Most physicians who make use of this service have found it an effective tool for collecting their fees at the time of service. They notice a marked reduction in the amount of the cost of sending out statements, and the cost of in-office collection efforts.

In making decisions to offer new services or to endorse products and/or services, the Physician Service Group considers many factors.

Some of these factors are the overall contribution of the service to the smooth and efficient running of a physician's practice, the ability of the service or product to meet a large number of the physician's needs, and the availability of the services to physicians throughout the entire state.

Criteria MSMS uses to determine if a service is worthwhile is whether or not the party or organization to be utilized has had a significant background in the field; whether or not they have had experience in dealing with physicians in the past, and whether or not they are a proven organization, with an overall record of high quality and success. Other important criteria are whether or not the Physician Service Group's work force can satisfactorily meet the needs of the outside organizations, and whether or not the demands placed upon the Physician Service Group are within the staff's capabilities of expertise and/or staffing.

The Physician Service Group will embark upon any program or service that it feels can successfully meet the previous list of criteria.

Mr. Anthony is general manager of the MSMS Physicians Service Group, Inc.

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

James L. Adams, MD OPH
4870 Clark Rd.
Ypsilanti, 48197

Charles W. Baker, MD ON/IM
3011 W. Grand River Blvd. #773
Detroit, 48202

Frank E. Banfield, MD PD
144 W. 26th St.
Holland, 49423

Mostafa Bastanfar, MD AN/PDA
Henry Ford Hospital
Detroit, 48202

M. Nasir Baz, MD PD/AI
330 Lovell St.
Ionia, 48846

David L. Benkoff, MD IM/GE
17550 W. 12 Mile Rd.
Southfield, 48076

Dennis C. Besley, MD IM/CD
21 Michigan St., NE #430
Grand Rapids, 49503

Robert H. Burke, MD MFS/GS
1303 Packard
Ann Arbor, 48104

Edward C. Bush, MD FP
3180 Fort St.
Lincoln Park, 48146

Kanu B. Dalal, MD TR
416 Connable Ave.
Petoskey, 49770

David E. Eggert, MD GS/CDS
569 Wildwood Ave.
Jackson, 49201

Charles N. Ellis, MD D
2215 Fuller Rd. B501
Ann Arbor, 48105

Daniel S. Gadzinski, MD EM
7324 Cavell
Westland, 48185

Michael E. Gates, MD EM
622 S. Angola Rd.
Coldwater, 49036

Amitava Ghosh, MD GS
427 S. Elizabeth
Mt. Pleasant, 48858

Philip C. Haines, MD CHP/P
825 Parchment Dr., SE
Grand Rapids, 49506

Dale V. Hoekstra, MD ORS
Henry Ford Hosp., ORS Dept.
Detroit, 48202

Martin P. Kafka, MD P
300 Pineridge
Ann Arbor, 48103

Velji K. Kansara, MD U
6001 W. Outer DR., #201
Detroit, 48235

David J. Kearney, MD U
1915 E. Fourteen Mile Rd.
Birmingham, 48008

S. Jean Kegler, MD D
1104 St. Aubin
Detroit, 48207

Surendra M. Kumar, MD U/AN
3610 Windemere
Ann Arbor, 48105

Young Jo Kwon, MD P
15101 Southfield Rd.
Allen Park, 48101

James O. Kumi, MD IM
22151 Moross Rd., #231
Detroit, 48236

Victor B. Lebedovych, MD GS
211 S. Crapo St.
Mt. Pleasant, 48858

Eglis T. Lode, MD IM
13120 Beck Rd.
Plymouth, 48170

David G. Logan, MD P
1130 Hill St.
Ann Arbor, 48104

V. Mahadev, MD IM/CD
301 Kent St.
Iron Mountain, 49801

Andrew J. Mitchell, MD D
Henry Ford Hosp. Dept/Derm.
Detroit, 48202

Vijay K. Mittal, MD GS
6001 W. Outer Dr. #201
Detroit, 48235

Mark O. Moleski, MD OPH
26 Sheldon Ave., SE
Grand Rapids, 49503

Ildiko V. Molnar, MD IM
20555 Ecorse Rd.
Taylor, 48180

Henry J. Mulder, MD P
933 Orchard Ave., SE
E. Grand Rapids, 49506

Jeffrey L. Musson, MD OBG
872 Forest Hill, SE
Grand Rapids, 49506

Sang H. Oh, MD OBG
200 S. Wenona #298
Bay City, 48706

Timothy D. Oliver, MD FP
115 S. Main
Perry, 48872

Gregg A. Patten, MD IM/PUD
502 Lansing Ave.
Jackson, 49201

William F. Patton, MD IM/PUD
3075 Clark Rd. #300
Ypsilanti, 48197

Gary D. Poelman, MD GS
870 Brentwood, SW
Jenison, 49428

John Popovich, Jr., MD PUD/IM
Henry Ford Hosp.
Detroit, 48202

Kenneth W. Post, MD GS
1900 Wealthy St., SE #190
Grand Rapids, 49506

L. Millilineni Prasad, MD IM
27549 Six Mile Rd.
Livonia, 48152

Richard T. Robinson, MD IM
17555 James Couzens
Detroit, 48235

Rod J. Rohrich, MD PS
1113 Maiden Lane Ct. #105
Ann Arbor, 48105

Alan H. Rosenbaum, MD P
Henry Ford Hosp. Dept/Psych.
Detroit, 48202

David R. Scrase, MD IM
3075 Clark Rd.
Ypsilanti, 48197

Vikas M. Shah, MD AN
Henry Ford Hosp. Dept/Anes.
Detroit, 48202

Abdulkader M. Shamayleh, MD PD
Wyandotte Gen. Hosp.
Wyandotte, 48192

NEW MEMBERS/*Continued*

Manorama Sharma, MD OBG
35992 S. Gratiot
Mt. Clemens, 48043

Oscar R. Signori, MD IM/ON
19855 Outer Dr.
Dearborn, 48124

Robert B. Stanley, Jr., MD OTO
8200 E. Jefferson #909
Detroit, 48214

Edward W. Stilwill, MD DR
321 Knollwood Dr.
Traverse City, 49684

Jinka Subramanya, MD PTH
Paul Oliver Memorial Hosp.
Frankfort, 49635

Charles J. Sutherland, MD ORS
Henry Ford Hosp.
Detroit, 48202

Joe G. Talbert, MD TS/GS
3800 Woodward Ave. #914
Detroit, 48201

Gerald B. Thomas, MD IM
5230 State St.
Saginaw, 48603

Kirit K. Tolia, MD IM/END
41935 W. 12 Mile Rd.
Novi, 48050

Charles G. Todoroff, MD IM
2021 Monroe #301
Dearborn, 48124

Sudhir Walavalkar, MD IM
21460 Bournemouth #203A
Harper Woods, 48225

Clifford F. Wiegand, MD IM/NEP
560 W. Mitchell St.
Petoskey, 49770

Steven A. Yarows, MD IM
775 S. Main St.
Chelsea, 48118

Joseph P. Zobro, MD FP
1110 Rockland Rd.
Ontonagon, 49953

VA has new physician clearing house

The Veterans Administration has recently established a physician clearinghouse to enable VA medical centers and interested physicians to more readily identify each other. The clearinghouse allows physicians to apply for openings throughout the entire VA system by submitting a single application and set of references.

Through the clearinghouse, qualifications and practice preferences are matched with VA needs within 24 hours to generate a list of interested, qualified applicants for each physician vacancy. The application and references of each "matched" applicant are forwarded to the requesting medical center where interviews are held and evaluations and hiring decisions are made.

For further information and application, contact: VA Physician Placement Service; P.O. Box 719; Randolph, MA 02368.

Prepare For:
- TOEFL
- MSKP
- NATIONAL MEDICAL BDS
- VQE
- ECFMG
- FLEX
- DENTAL BDS
- PODIATRY BDS
- NURSING BDS

- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.
- Over 40 years of experience and success in the field of test preparation.

Stanley H. KAPLAN EDUCATIONAL CENTER

For Information Please Write or Call:
Crossroads Office Centre
16250 Northland Drive
Southfield, MI 48075
(313) 569-5320
Centers In More Than 80 Major US Cities, Puerto Rico, Toronto, Canada & Zurich, Switzerland.

ANNOUNCING THE C.L.I.C.

SPEAKERS BUREAU

Now scheduling PRESENTATIONS on the following investment topics:
- GOLD & SILVER BULLION
- RARE COINS

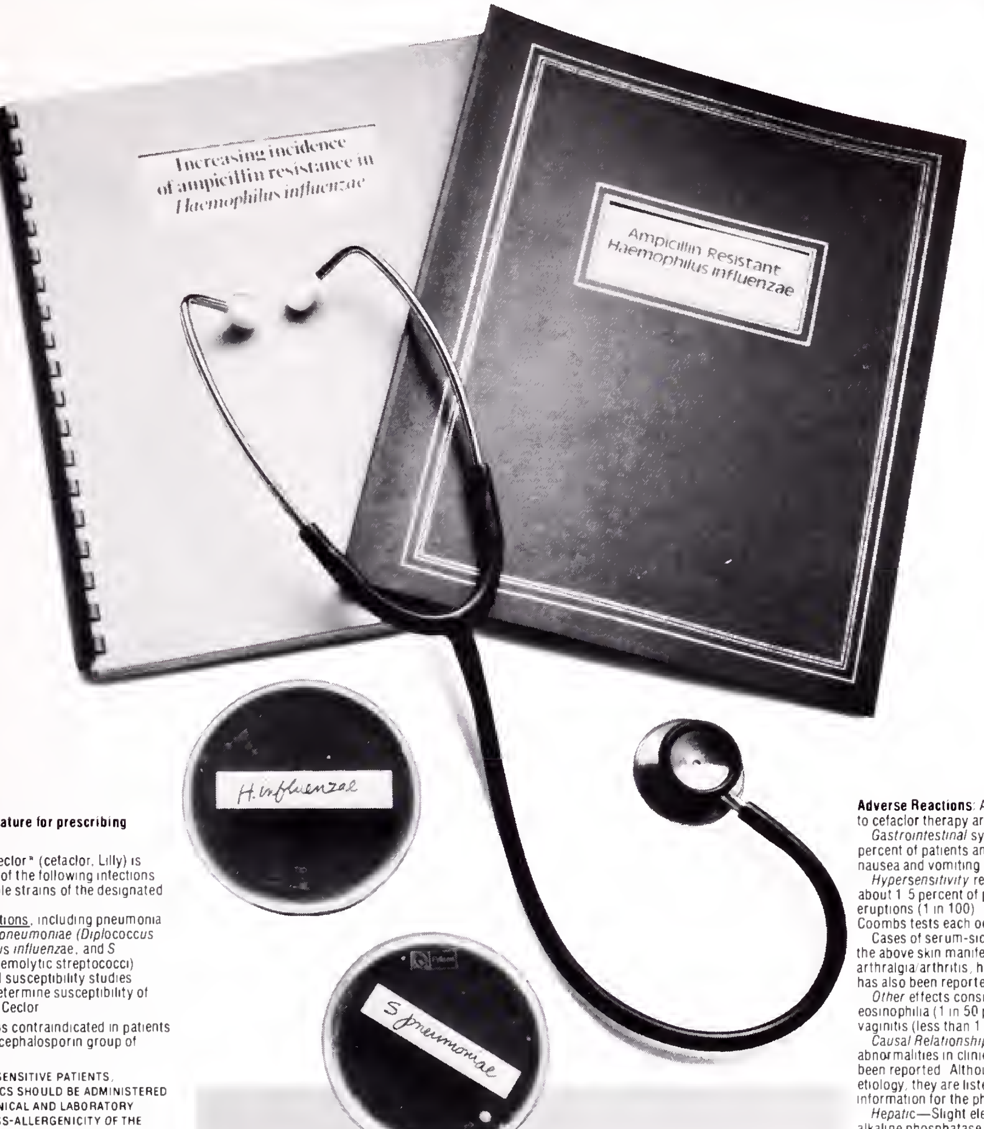
To schedule a highly enlightening presentation for your next business meeting, contact:

CARLTON LUSH INVESTMENT CORPORATION
Bingham Center • Suite 1646
30700 Telegraph Road • Birmingham, Michigan 48010
(313) 646-8846

Life Members: ANA, CNA, MSNS

CANADA
999
FINE GOLD 1 OZ OR PUR
KRUGERRAND
19
FYNGOUD
1845

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g, pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [103080R]

---

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* [8]

Note Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

1 Antimicrob Agents Chemother, *8* 91, 1975
2 Antimicrob Agents Chemother, *11* 470, 1977
3 Antimicrob Agents Chemother, *13* 584, 1978
4 Antimicrob Agents Chemother, *12* 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880 Washington, D C American Society for Microbiology, 1978
6 Antimicrob Agents Chemother, *13* 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr, and J E Bennett), p 487 New York John Wiley & Sons, 1979

Lilly

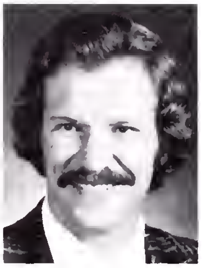
Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc,
Carolina Puerto Rico 00630

100061

NEWS

By Sheri W. Greenhoe
East Lansing


Doctor Bock

Doctor Kahkonen

Doctor Haddock

Doctor Wilson

Michigan Thoracic Society recently awarded its Bruce Douglas Award to **John G. Weg, MD,** U-M Medical Center, for his outstanding contributions to the respiratory health of Michigan citizens. . . . Alpena physician **William E. Nesbitt, MD,** and **D. R. Smith, MD** of Iron Mountain, each have maintained a quarter century of membership and service in the American Academy of Family Physicians. They were among those physicians honored in a special ceremony at the Academy's annual convention in Las Vegas. . . . New director of the Upper Peninsula Medical Education Program is **John Hickner, MD,** Escanaba. . . . **Dorothy Kahkonen, MD,** Dearborn, was re-elected president of the American Diabetes Association — Michigan Affiliate at its annual meeting in Southfield. . . . Ann Arbor physician **Manus Krasman, MD** was presented the Dan W. Myers, MD, Award for excellence in teaching for the clinical faculty at Harper-Grace Hospitals — Grace Hospital Division. . . . **Brooks F. Bock, MD,** is new vice-president of the board of directors of the American College of Emergency Physicians. . . . **Ray H. Littleton, MD,** Detroit, has been selected as one of the Outstanding Young Men of America for 1981, for excellence in professional endeavors and civic activities. . . . **William Cayce, MD,** Grand Rapids has been appointed by Gov. Milliken to the Michigan Certificate of Need (CON) Board. The Michigan Senate must confirm Doctor Cayce. . . . The Oscoda-AuSable Chamber of Commerce presented **Jayne W. Dye, MD** and **W. F. Blake Kutsche, MD,** with certificates of appreciation for their service to the community at a recent community dinner. . . . **Charles Seifert, MD,** Battle Creek urologist, was elected president of the Southwest Michigan Health Systems Agency at the HSA's annual board meeting in August. . . . Still making housecalls at age 77, **Jerrian Van Dellen, MD,** continues to practice medicine as a service to his patients, as he has throughout his 47-year medical career. Doctor Van Dellen was the subject of a recent feature article in the Petoskey *News-Review*. . . . A recent Upper Peninsula Medical Society meeting on Mackinac Island brought dual honors for Escanaba physician **William LeMire II, MD.** In addition to receiving one of four achievement awards, Doctor LeMire was honored by Abbott Laboratories for his 50 years of dedication to medicine and to the people of Delta County. . . . The American Academy of Family Physicians Board of Directors has elected **Douglass A. Haddock, MD,** of Kalamazoo chairman of the Board. He has served on a number of AAFP commissions and committees, most recently as chairman of the Commission on Education. . . . Grand Rapids physician **John Wilson, MD,** was honored with a Michigan House of Representatives resolution lauding his professional and civic accomplishments. The resolution was co-sponored by five State Representatives, and enumerated his professional achievements and his volunteer contributions to Kent County's emergency medical system. . . . 300 Port Hope citizens turned out to honor **J. H. Earnshaw, MD,** the town's "number one citizen" at a recent community dinner in appreciation of his 43 years of service. . . . **Arthur L. Foley, MD, PhD,** was made an honorary member of the College of Human Medicine Alumni Association of Michigan State University. He was cited for distinguished service to MSU and to those graduates whose professional careers will benefit from his inspiration. . . . Traverse City physicians **James Mudgett, MD,** and **Jim Woodburne, MD** recently ran in an "ultra marathon" — a 50-mile race in the Keweenaw Peninsula. Mudgett completed the race in seven hours and 24 minutes, and Woodburne in eight hours and 16 minutes. . . . University of Michigan Medical School Professor of Pharmacology, **Edward F. Domino, MD,** was recently honored in Michigan, Illinois and Japan for his research and teaching in psychopharmacology. The University of Illinois Alumni Association presented Doctor Domino with a Distinguished Graduate Award for service to research and education; the Japanese Pharmacology Society honored him by designating him the keynote speaker for the Society's 54th annual meeting; and the Michigan Psychiatric Society awarded Doctor Domino a certificate of merit for his "outstanding achievements as an educator of psychiatrists in psychopharmacology, avid scholarship and meaningful research."

Ms. Greenhoe is editorial secretary to *Michigan Medicine.*

YOU COULDN'T PICK A BETTER CARD.

Why not consider one of these Blue Cross and Blue Shield of Michigan programs? They have been especially designed to meet the needs of Michigan State Medical Society members and their employees. Whichever you choose, you'll get all the benefits that characterize the best health care coverage available:

☐ The I.D. card that's recognized everywhere.
☐ No cash deposits required for covered services with participating hospitals.
☐ A minimum amount of paperwork.
☐ A statewide network of Blue Cross and Blue Shield Service Centers to assist you and your employees.
☐ No physical examinations required.
☐ Pre-existing health conditions are covered.
☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too? For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

OPTION I — Comprehensive Plan

☐ Hospital care benefits
☐ Medical/Surgical benefits
☐ Reciprocity for outstate physician services
☐ Catastrophic Master Medical coverage
☐ Supplement to Medicare

OPTION II — Comprehensive Plan (hospital coverage only)

☐ Hospital benefits
☐ Supplement to Medicare Complementary Coverage

OPTION III — Econo 30% Subscriber Co-Payment Plan

☐ Hospital care benefits
☐ Medical/Surgical benefits
☐ Supplement to Medicare Complementary Coverage

An Econo Plan with hospital coverage *only* is also available.

Employee Program for Michigan State Medical Society Members

☐ Hospital care benefits
☐ Physician care benefits
☐ Supplement to Medicare Complementary Coverage

Blue Cross Blue Shield of Michigan
EFFECTIVE DATE OF CURRENT COVERAGE 09 01 81
SUBSCRIBER NAME DEBORGIA ALAN
GROUP NO. 81777
SERVICE CODE 1270 (BLUE CROSS) 7007 (BLUE SHIELD) 3260 (BC•BS)
CONTRACT NUMBER 365 036 429
BC PLAN CODE 0 210
BLUE CROSS OF MICHIGAN (210) BLUE SHIELD OF MICHIGAN (710) DETROIT MICH 48226

IT'S GOOD TO BELONG.

Blue Cross Blue Shield of Michigan

You can spend your money getting there. . .

SKI in COLORADO

from **$472***

This price only gets you a plane ticket to Denver.

You get:

- **No** lodging
- **No** lift tickets
- **No** food included
- **No** bus or rental car from airport to ski area

*Detroit to Denver Coach Airfare

. . .or spend your money skiing

SKI BOYNE USA

$320 complete

For the cost of a plane ticket the sensibly priced Boyne USA Ski Week includes everything:

You get:

- **5 nights lodging**
- **5 days lift tickets**
- **Three meals each day**
- **Instruction from the Boyne Austrian Ski Schools.**

This winter, ski Boyne Mountain.
The cost comparison says it all!
Weekend packages at $120.

Boyne USA
RESORTS
BIG SKY · BOYNE MOUNTAIN · BOYNE HIGHLANDS

For complete information or reservations call your travel agent or BOYNE USA.

Mich. residents 800-632-7174
Out of Michigan 800-253-7072

Now in our 33rd winter of the Midwest's finest skiing.

Boyne USA RESORTS
BIG SKY · BOYNE MOUNTAIN · BOYNE HIGHLANDS

1981-1982

MEDICAL/DENTAL MEETINGS

BOYNE HIGHLANDS
Harbor Springs, MI

NAME AND GROUP CONTACT	ARRIVAL/ DEPARTURE	TYPE
EMERGENCIES IN MEDICINE Dr. Robert Wilson	1/10-1/15, '82	
TRI-STATE DENTAL Dr. Donald DeCenso	1/10-1/15, '82	
OHIO VETERINARY MEDICAL ASSOC. Dr. George Norris	1/24-1/29, '82	
FAMILY PRACTICE UPDATE CONFERENCE Janet Johnson	1/31-2/5, '82	
MICHIGAN OPTOMETRIC ASSOCIATION Dr. Phillip Irion	2/14-2/19, '82	
BOYNE WINTER IMAGING SEMINAR Dr. Robert Bree	2/14-2/19, '82	

BOYNE MOUNTAIN
Boyne Falls, MI

NAME AND GROUP CONTACT	ARRIVAL/ DEPARTURE	TYPE
MID-WINTER MEDICAL MEETING Dr. Michael Hughes	1/24-1/29, '82	
MICHIGAN HEART ASSOCIATION Eleanor Peterson, R.N.	1/31-2/5, '82	

BIG SKY OF MONTANA

NAME AND GROUP CONTACT	ARRIVAL/ DEPARTURE	TYPE
AMERICAN ASSOCIATION OF DENTISTS Morris Travel	1/16-1/23	National
ACADEMY OF FAMILY PHYSICIANS D.J. Breen, MD Hillsboro Clinic	1/24-1/30	National
MONTANA PHYSICAL THERAPY ASSOC. Diane C. Allen, LPT	1/22-1/24	State
BIG SKY RADIOLOGY Dr. Virgil B. Graves Dept. of Radiology Columbus Hospital	2/1-2/6	National
MONTANA ACADEMY OF OPHTHALMOLOGY Dr. Kenneth Younger	2/11-2/14	Regional
MONTANA ACADEMY OF DERMATOLOGY Dr. Ronald Orman	1/12-2/15	Regional
CARDIOLOGY SEMINAR Dr. Sidney Goldstein Head-Division of Cardiovascular Medicine Henry Ford Hospital	2/13-2/20	National
TRI-STATE DENTAL/ MEDICAL Hugh Henning, DDS	2/20-2/27	Regional
TOPICS IN INTERNAL MEDICINE Frances Burt	2/23-2/28	National
ANESTHESIOLOGY SEMINAR Mrs. Phyllis Sherburne Director of Educational Services Columbus Hospital	2/24-2/28	National
OB/GYN SOCIETY Dr. John Browne	3/3-3/7	Regional
BIG SKY UROLOGICAL SOCIETY Dr. Robert Towers	3/4-3/7	National
WESTERN ORTHOPEDIC ASSOCIATION James F. Schwarten, MD The Billings Clinic	3/5-3/7	Regional
CONTINUING EDUCATION SEMINAR, MEDICAL COLLEGE OF GEORGIA Morris Travel	3/7-3/13	National
MONTANA SOCIETY OF DENTISTRY FOR CHILDREN Dr. Thomas Wickliffe	3/18-3/21	State
PULMONARY DISEASES COURSE Terrie vanAllen Extended Programs in Medical Education	3/20-3/27	National
"ACHA Hospital Liability and the Quality of Patient Care" Eugenia Shuller Am. College of Hospital Administrators	1/16-1/23, '82	National
AMERICAN LUNG ASSN. OF MONTANA Earl Thomas	1/28-1/31 '82	State

For specific information regarding meeting programs and speakers, call Mitzi Kehn at Big Sky of Montana (800-548-4486) or Donna Prested at Boyne Mountain (616) 549-2441, collect.

Executives of Component Societies of MSMS

Berrien County Medical Society
Eunice S. Ott, Exec. Secretary
5979 DeField Rd., Coloma 49038
(616) 983-7829

Genesee County Medical Society
Norman Anderson, Exec. Director
806 W. Sixth Ave., Flint 48503
(313) 238-3781

Ingham County Medical Society
John B. Kantner, Exec. Director
P.O. Box 770, East Lansing 48823
(517) 332-8021

Jackson County Medical Society
R. W. Swartley, Exec. Secretary
334 W. Franklin, Jackson 49201
(517) 784-5682

Kalamazoo Academy of Medicine
Miss Mary Agar, Exec. Secretary
433 S. Rose St., Kalamazoo 49006
(616) 342-8502

Kent County Medical Society
William G. McClimans, Exec. Secretary
1155 Front NW, Grand Rapids 49504
(616) 458-4157

Macomb County Medical Society
Mrs. Nelda Gasperson, Exec. Director
409 Macomb Daily Bldg., Mt. Clemens 48043
(313) 463-2101

Monroe County Medical Society
Marie Gibson, Exec. Secretary
416 Sackett Avenue, Monroe 48161
(313) 241-8665

Muskegon County Medical Society
Donald Fairfield, Exec. Secretary
P.O. Box 445, Muskegon 49443
(616) 726-3511

Oakland County Medical Society
Mrs. Mary Sue Meyer, Exec. Director
346 Park St., Birmingham 48009
(313) 646-5400

Saginaw County Medical Society
Carl G. King, Exec. Secretary
P.O. Box 1868, Saginaw 48605
(517) 753-8722

Washtenaw County Medical Society
Miss Sallie J. Schiel, Exec. Secretary
708 W. Huron, Ann Arbor 48103
(313) 668-6241

Wayne County Medical Society
Roger F. Mecum, Exec. Director
1010 Antietam Rd., Detroit 48207
(313) 567-1640

Component society officers

Allegan
President: D. S. Sprague, MD, Allegan; Secretary: A. Gonzalez, MD, Med. Pathfinder Lab., Fennville 49408.

Alpena-Alcona-Presque-Isle
President: C. R. Anderson, MD, Alpena; Secretary: Peter Aliferis, MD, Alpena General Hosp., Alpena 49707.

Barry
President: Thomas G. Hicks, MD, Hastings; Secretary: Eldon E. Cassell, MD, Pennock Hospital, Hastings 49058.

Bay-Arenac-Iosco
President: Paul W. Rowe, MD, Bay City; Secretary: H. I. Blumenstein, MD, 1560 Kinney Ct., Essexville 48732.

Berrien
President: J. A. Valantiejus, MD, Harbert; Secretary: Gideon D. Medina, MD, 115 S. St. Joseph, Niles 49120

Branch
President: Donald Paarlberg, MD, Coldwater; Secretary: Frank W. Moler, MD, 292 E. Chicago St., Coldwater 49036.

Calhoun
President: L. E. Dorfman, MD, Battle Creek; Secretary: B. J. Cassin, MD, 175 College St., Battle Creek 49017.

Cass
President: A. G. Lira, MD, Niles; Secretary: Jashu N. Patel, MD, 515 Main St., Dowagiac 49047.

Chippewa-Mackinac
President: Hugh R. Allott, MD, Sault Ste. Marie; Secretary: Rassul S. Saber, MD, 500 Osborn Blvd., Sault Ste. Marie 49783.

Clinton
President: A. N. San Juan, MD, St. Johns; Secretary: W. F. Stephenson, MD, 510 E. Walker, St. Johns 48879.

Delta
President: Ali H. Sawaf, MD, Escanaba; Secretary: James W. Clay, MD, Rte #2, Box 14B, Gladstone 49837.

Dickinson-Iron
President: Wm. A. Belding, MD, Iron Mountain; Secretary: Ray S. Koivunen, MD, 1500 W. Ice Lake Rd., Iron River 49935.

Eaton
President: G. S. Stipanuk, MD, Eaton Rapids; Secretary: R. L. Leeser, MD, 210 W. Oliver, Charlotte 48813.

Genesee
President: R. J. McMurray, MD, Flint; R. M. Engelman, MD, 2744 Flushing Rd., Flint 48504.

Gogebic
President: J. R. Franck, MD, Wakefield; Secretary: D. L. Davidson, MD, 200 S. Sophie, Bessemer 49911.

Grand Traverse-Leelanau-Benzie
President: Gene D. Tang, MD, Traverse City; Secretary: Arthur F. Dundon, MD, 1100 Sixth St., Traverse City 49684.

Gratiot
President: Kevin P. Foley, MD, Alma; Secretary: James K. Hall, MD, 160 Warwick Dr., Alma 48801.

Hillsdale
President: Arthur J. Stein, MD, Hillsdale; Secretary: Charles T. Vear, MD, 209 S. Howell, Hillsdale 49242.

Houghton-Baraga-Keweenaw
President: Peter E. Carmody, MD, L'Anse; Secretary: J. Q. DeGuzman, MD, Houghton-Baraga-Keweenaw Co., 821 Water St., Hancock 49930.

Huron
President: E. E. Steinhardt, MD, Bad Axe; Secretary: Richard E. Lockard, MD, 40 N. Main St., Elkton 48731.

Continued on page 658

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN

Healthy Competition Makes A Healthier Market

Physicians Insurance Company of Michigan,
The Successor to The Brown-McNeely Insurance Fund,
Your Competitive Source for Medical Professional Liability Insurance.

Occurrence Coverage

Choice of limits— $100,000/$300,000 or $200,000/$600,000

No charge for corporation coverage, if all members are insured with PICOM

Consent of insured required for settlement, before judgement, of any claim covered by the policy

For a rate quotation and additional information, contact:

PHYSICIANS INSURANCE
COMPANY OF MICHIGAN
6810 South Cedar Street, Suite 12
Long Commerce Park
Lansing, Michigan 48910
(517) 694-3500

COMPONENT OFFICERS/*Continued*

Ingham
President: R. C. Kinzel, MD, Lansing; Secretary: J. C. Spencer, MD, Edw. W. Sparrow Hospital, Lansing 48902.

Ionia-Montcalm
President: C. E. Stevens, MD, Greenville; Secretary: L. E. Sanford, MD, 302 S. Bridge St., Belding 48809.

Isabella-Clare
Secretary: F. D. Johnson, MD, Mt. Pleasant; Secretary: J. M. Caldwell, MD, 314 S. Brown St., Mt. Pleasant 48858.

Jackson
President: J. W. Wilkins, MD, Jackson; Secretary: L. E. Jennings, MD, 123 N. West Ave., Jackson 49201.

Kalamazoo
President: E. J. Alberding, MD, Portage; Secretary: Fredk. W. Bald, MD, 402 Bronson Medical Ctr., Kalamazoo 49006.

Kent
President: S. C. Bauserman, MD, Grand Rapids; Secretary: W. S. Stawski, MD, 1900 Wealthy St., SE, Grand Rapids 49506.

Lapeer
President: Merle B. Haney, MD, Romeo; Secretary: Leon R. Boruch, MD, 834 Liberty St., Lapeer 48446.

Lenawee
President: Xenophon Skufis, MD, Adrian; Secretary: Nancy S. Newlin, MD, 710 W. Pottawatamie, Tecumseh 49286

Livingston
President: S. L. Hoffman, MD, Howell; Secretary: C. A. Creighton, MD, 1200 Bryon Rd., Howell 48843.

Luce
President: C. W. Dunn, MD, Newberry; Secretary: R. D. Gibson, MD, 207 W. John St., Newberry 49868.

Macomb
President: G. G. Brueckner, MD, Mt. Clemens; Secretary: R. M. Kommel, MD, 26510 Dundee, Huntington Woods 48070.

Manistee
President: R. R. Knoblich, MD, Manistee; Secretary: A. F. Xavier, MD, 310 Ninth St., Manistee 49660.

Marquette-Alger
President: John M. Coyne, MD, Marquette; Secretary: J. F. Gephart, MD, 420 W. Magnetic, Marquette 49855.

Mason
President: J. E. Van Kuiken, MD, Ludington; Secretary: Gerry L. Mayer, MD, 806 Russell St., Ludington 49431.

Mecosta-Osceola-Lake
President: J. M. Wolschleger, MD, Big Rapids; Secretary: Leonard Reedyk, MD, 413 Mecosta Ave., Big Rapids 49307.

Menominee
President: Edw. J. Pienkos, MD, Menominee; Secretary: W. S. Jones, Jr., MD, 1146 Tenth Ave., Menominee 49858.

North Central
President: K. W. Waterfall, MD, Gaylord; Secretary: C. L. Gosling, MD, Fam. Practice Ctr. Rte. 2, Grayling 49738.

Midland
President: L. C. Christensen, MD, Midland; Secretary: James H. Frye, MD, 1412 E. Wackerly Rd., Midland 48640.

Monroe
President: Kanti H. Shah, MD, Monroe; Secretary: Ihsan U. Haq, MD, 905 N. Macomb St., Monroe 48161.

Muskegon
President: J. W. Crawford, MD, Muskegon; Secretary: J. A. Leinicke, MD, Hackley Med. Cntr. #300, Muskegon 49442.

Newaygo
President: R. C. Clouse, MD, Fremont; Secretary: D. B. Reinders, MD, 230 W. Oak St., Fremont 49412.

Northern Michigan
President: C. A. Tressler, MD, Petoskey; Secretary: D. N. Mikhail, MD, Burns Clinic Med. Ctr., Petoskey 49770.

Oakland
President: K. L. Urwiller, MD, Pontiac; Secretary: Michael Garcia, MD, 4400 Prud. Town Ctr. #275, Southfield 48075.

Oceana
President: V. Dale Barker, MD, Hart; Secretary: V. Dale Barker, MD, 17 Courtland St., Hart 49420.

Ontonagon
President: Steven N. Gervae, MD, Ontonagon; Secretary: Steven N. Gervae, MD, 511 Mors St., Ontonagon 49953.

Ottawa
President: L. E. Nelson, MD, Grand Haven; Secretary: Donald M. Fix, MD, 17950 Holcomb Rd., Grand Haven 49417.

Saginaw
President: Michael T. Bergeon, MD, Saginaw; Secretary: Jacob C. Ninan, MD, P.O. Box 2253, Saginaw 48605.

St. Clair
President: J. W. Copping, MD, Port Huron; Secretary: J. M. Murphy, MD, 1313 Stone St., Port Huron 48060.

St. Joseph
President: J. E. Phillips, MD, Sturgis; Secretary: T. E. Brenner, MD, 600 S. Lakeview, Sturgis 49091.

Sanilac
President: F. H. El-Ghazzi, MD, Sandusky; Secretary: R. I. Cutcher, MD, 2443 Black River St., Deckerville 48427.

Schoolcraft
President: John M. Clark, MD, Manistique; Secretary: Robert J. Urban, MD, 115 Lake St., Manistique 49854.

Shiawassee
President: Charles W. Webb, MD, Owosso; Secretary: D. F. Strong, MD, 1105 W. King St., Owosso 48867.

Tuscola
President: Maurice H. Chapin, MD, Millington; Secretary: Edw. J. Miles, MD, 261 Golfview, Caro 48723.

Van Buren
President: Larry G. Goss, MD, Bangor; Secretary: R. A. Farber, MD, 302 Harris St., Paw Paw 49079.

Washtenaw
President: F. E. Patterson, MD, Ann Arbor; Secretary: L. H. Wolin, MD, 2216 Midford Rd., Ann Arbor 48104.

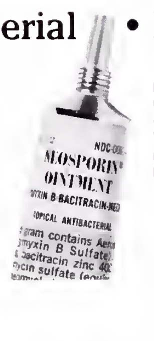
Wayne
President: Robert W. Black, MD, Detroit; Secretary: Susan E. Adelman, MD, 29820 Woodland Dr., Southfield 48034.

Wexford-Missaukee
President: R. D. Simmons, MD, Cadillac; Secretary: T. W. Tatarchuk, MD, 828 Oak St., Cadillac 49601.

First Class First Aid

In your office
In their homes
Recommend
NEOSPORIN® Ointment
(POLYMYXIN B-BACITRACIN-NEOMYCIN)

- Broad-spectrum antibacterial
- Handy applicator tip



DESCRIPTION: Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and ½ oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

MSMS arms physician leaders to meet difficult economic times

Physician leaders came to the conference from all around, as evidenced by this grouping. From left are MSMS Council Chairman Thomas R. Berglund, MD, Portage; former AMA President Edward Annis, MD, of Miami, FL; AMA Trustee John J. Coury, MD, Port Huron, and MSMS Secretary Robert M. Leitch, MD, Battle Creek.

By Judith Marr
East Lansing

"We stand on the brink of two difficult choices. One of our choices is for desperation, misery and deprivation. The other choice is for total destruction."

— Woody Allen

"I hope to God we make the right decision," prayed William R. D. Martin, PhD, dean, School of Management, University of Michigan, Dearborn. Doctor Martin quoted Woody Allen's humorous doomsday observation as he spoke to a standing-room-only crowd at the 1981 MSMS Public Affairs/Leadership Conference in Lansing Oct. 22.

Doctor Martin linked Woody Allen's choices to those physicians face in today's Michigan economy and changing medical practice climate.

His talk, as did most of those of the day, related to the Michigan economy and its gloomy outlook for all.

"We are faced with unbelievable challenges as citizens," said Fred E. Patterson, MD, Jackson, chairman of the conference.

"The charisma of leadership is something one has or has not. But the other hallmark of leadership is knowledge. The MSMS House of Delegates recognized this when they called for leadership training for officers and board members. This conference is tailored to address this challenge."

To better arm the MSMS leaders, component society officers, auxiliary members and others at the conference that day, MSMS provided a roster of speakers who discussed current health care legal issues, the Michigan budget, supply-side economic theory as espoused by the Reagan administration, the current priorities of the AMA and of MSMS, cost containment and the supply of physicians.

'We're in trouble'

The depressing impact of soaring inflation and interest rates on the Michigan economy was fervently and soberly put to the MSMS audience through the address of State Budget Director Gerald Miller.

Miller began by intoning, "As a state we're in trouble."

He called for the physicians' consideration and help, because, he said, "your opinion and understanding are very important to what we're doing. You can have an impact in your communities."

Miller was fresh from the previous evening's announcements by Governor Milliken of a new $270 million budget cut, which was in addition to the $124 million cut during the previous year.

"This recession won't go away," said Miller. "We've hit bottom in term of the major economic variables we're looking at, the economy continues to stagnate, unemployment is as high as it was in January, and there's no improvement."

High interest rates are the primary culprit, he said, and they have a disproportionate effect on Michigan, with its reliance on durable goods industries.

He said recovery is not expected in state executive offices until at least the middle of next year, and that the governor's program announced the previous night to improve the Michigan climate for jobs is essential.

To encourage economic development in the state, property tax relief will have to be delayed, he announced.

"It can't be afforded now," he said. "The only way we could afford it would be to get revenue from other sources."

Michigan leads the country in the extent of its budget decline, he said. The FY 1981 budget is seven percent below the previous year's budget in current dollar terms.

"No other jurisdiction in our knowledge has written such a budget," he said. "In real terms, $1 billion has been cut back from the January, 1980 budget."

He said the MSMS and MAOPS proposal for a cost saving alternative

Michigan State Medical Society Membership Insurance Benefits

Are you aware of the insurance available to you as an MSMS member?

On the following two pages is a summary of the member benefit insurance coverages which are available to you through the Michigan State Medical Society. All members are encouraged to review this information to be fully aware of all the benefits available and to determine if and where these coverages may fill a void or supplement your existing insurance program.

Any questions or comments regarding these programs may be directed to Wayne Burmeister, manager, Department of Operations and Member Services, Michigan State Medical Society Headquarters, 120 W. Saginaw, East Lansing, 48823 (Telephone — 517/337-1351).

Please remove this insert for handy reference in your files.

Member benefits available for Michiga

Type	Coverage Available	Special Features
1. **Disability Income Protection Accident & Sickness**	Optional amounts up to $1,500 monthly benefit. Benefits paid from the 1st & 16th day, 30th day, or 90th day of disability; and, benefit duration is lifetime for accident and up to age 65 for sickness, depending on the plans selected. Coverage automatically includes waiver of premium, accidental death & dismemberment coverage, up to 7 days indemnity for non-disabling injuries, & partial disability payments. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	New members guaranteed $500 monthl fit, regardless of medical history. Ind paid for first 15 days of hospital confinem sickness. Guaranteed conversion if m leaves the state to continue full time pra another state. Claims not pro-rated bec benefits received from other insurance.
2. **Business Overhead Disability Coverage**	Optional amounts up to $3,000 monthly benefit. Reimbursement for office expenses; i.e., rent, employees' salaries, utilities, malpractice insurance premiums, etc., during a period of total disability. Benefits payable from the 16th day of disability. Benefits are payable until the Maximum Overhead Expense Benefit Limit is reached — which is the monthly benefit times twenty-four. Waiver of premium is automatically included. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premiums constitute a business expen are deductible from gross income befor (IRS, 55-264, I.R.B. 1955-19, p. 8).
3. **Term Life Insurance**	Available in amounts of $25,000, $50,000, $75,000 or $100,000. Renewable to age 70 (amount reduced at age 65). Waiver of premium is included. Full conversion available to the Permanent Life Insurance Plan after policy is in force one year. This plan is underwritten by The Mutual Benefit Life Insurance Company, Newark, New Jersey.	New MSMS members guaranteed $2 regardless of medical history. Partici members are eligible to share any divi that become payable. Guaranteed conve to ordinary life if membership is discont Conversions also available to Permaner at age 65 reduction and age 70 termination
4. **Special Accidental Death & Dismemberment Benefits**	Provides benefits for loss of life, limbs, or sight as the result of an accident in amounts of $25,000, $50,000, $75,000, or $100,000. Coverage for the spouse may be purchased — the amount will be 50% of the member's principal sum. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Around-the-clock protection and worl coverage. Sports and recreation as well a fessional duties are fully covered. Renewa age 70.
5. **Disability Income Protection For Employees of Members**	Available in various amounts up to $500 monthly benefit. Choice of 7-day, 15-day, or 30-day waiting period for benefits to begin. Two benefit durations available: one-year accident/one-year sickness; and, five-years accident/two-years sickness. Waiver of premium included. This plan is underwriten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premium is a tax deductible expense whe by the employer.
6. **MEDGARD Professional Liability Insurance**	Limits of $100,000/$300,000; $200,000/$600,000; $1,000,000/$1,000,000 available in occurrence policy forms. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan — a physician-owned company.	A 75% premium discount to first-year titioners; 50% for most part-time or semi-r physicians. No charge for P.C./partne coverage. Premium financing available.
7. **MEDGARD Property & Liability Insurance**	Comprehensive property & liability insurance for physicians' offices and other property. Selection of optional coverages. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan.	Broadest all-risk replacement cost coverag surance designed specifically for physic Competitively priced. Advantage of one pany — total coverage.
8. **Hospital/Medical/Major Medical**	Excellent benefits to cover hospital, medical and major medical services. A separate benefit pro-	Four option coverages available to physi and their families, from comprehensive

te Medical Society members

istrators	Eligibility/How to Apply
-Cheeseman & Associates, Inc. bott Road, P.O. Box 1563 nsing, Michigan 48823	All MSMS members, under age 75, residing in Michigan, practicing full-time, may apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.
-Cheeseman & Associates, Inc. bott Road, P.O. Box 1563 nsing, Michigan 48823	All MSMS members residing in Michigan who practice full-time are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.
-Cheeseman & Associates, Inc. bott Road, P.O. Box 1563 nsing, Michigan 48823	All members, under age 70, active full time in a professional position, are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan) 1-800-292-1966.
-Cheeseman & Associates, Inc. bbott Road, P.O. Box 1563 nsing, Michigan 48823	All MSMS members, under age 70, engaged full time in their profession in the State of Michigan are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
-Cheeseman & Associates, Inc. bott Road, P.O. Box 1563 nsing, Michigan 48823	Employees, under age 60, who are employed full time by an MSMS member. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
-Cheeseman Management Company, bbott Road, P.O. Box 1563 nsing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for a free introductory kit. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550; or toll free (800) 292-1926.
-Cheeseman Management Company, bott Road, P.O. Box 1563 nsing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for specific information. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550; or toll free (800) 292-1926.
ss and Blue Shield of Michigan ayette East	Available to all MSMS members and their employees. Enrollment kit is available from MSMS Department of Member Services, 120 48823. (Tel

YOUR INCOME
Employees' Salaries
OFFICE RENT
Utilities

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc. Check these features of the Professional Overhead Expense plan sponsored by the MSMS.

- ☑ Up to $3,000 monthly benefit
- ☑ Waiver of Premium
- ☑ Survivors' Benefits
- ☑ Professional liability premiums are a covered expense
- ☑ Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more

"we're here to help"

Stratton–Cheeseman & Associates, Inc.

1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823
Call Toll Free: **800-292-1966**

*1979. The National Underwriter Company

An SRO crowd packed the Lansing meeting room for this most successful MSMS Leadership/Public Affairs Conference.

Medicaid utilization system is the basis for governmental budget cuts in that area. "All are looking at your pilot project in Wayne County with great interest," he said. "Innovative ideas like yours are going to play an increasingly important role in our cost control."

"How we handle Medicaid is very important, or it will break the state's budget," he said.

He also commented that the amount, $90 million, being spent on medical education in the state, "won't stand the test of time. We are turning out too many doctors."

He said he did not feel physicians are being asked to carry a disproportionate burden, only their fair share of a very difficult task ahead.

"Nostalgia may be fatal"

Physicians' futures are secure, assured Doctor Martin. But they will be different, he said.

The economic side of medical practice definitely will change for those physicians under 55, he predicted. Those 55 and over probably are secure, he said, but younger physicians will have to make adjustments.

Young physicians today may work for salaries in HMOs or proprietary hospitals, with 8 am. to 5 p.m. hours, and on call arrangements every fourth Sunday, he said.

"They will work hard, but will not have the experience of practicing by themselves. This may not be good, but it is another alternative."

Though physicians in the audience reminded him that it is not always feasible to do so, he called for them to get seats on their hospital boards and take other actions which will ensure them some control over their professional and economic lives.

"The trouble is," he observed, "that the people here have never been convinced that becoming involved will help their incomes or futures." He reminded them, however, that "preoccupation with nostalgia may be fatal in an age like today that demands innovation."

For all in the audience, he suggested a three-part solution to the dilemma of the changing economic climate:

1) Chart short and long-range plans in terms of medical practice, income, movability, group or hospital associations.

2) Commit time and energy to the plan.

3) Take concerted action to make the plan go.

'Supply-side fanatic'

Another speaker was Jude Wanniski, President Reagan's economic strategist and president of Polyconomics, Inc., political and economic communications firm of Morristown, New Jersey. Mr. Wanniski was formerly with the editorial pages of the *Wall Street Journal*.

Mr. Wanniski gave a detailed account of the rise and fall of the nation's economy, depending upon whether demand-side or supply-side economics were ascendant.

He was cornered during the lunch break by physicians anxious to apply his theories to Michigan economics. All the budget cutting won't do any good, claimed Wanniski, because that kind of action works on the wrong side of the equation.

He never had a course in economics ("Arthur Burns once told me, 'My boy, that's your advantage!'"), and is a journalist and political scientist by training. But he became a supply-side economics "fanatic" after an "illumination" in 1974, when he said he saw what was wrong with the world economy and what it would take to get it fixed.

Wanniski was pleased, he told the luncheon-break huddle, to have the opportunity to spread his supply-side gospel. His recent book, "The Way the World Works: How Economies Fail — and Succeed," lays out that gospel in detail.

Economic recovery won't begin until the interest rate comes down, he said. And that won't happen until

Doctor Martin

Doctor Miller

the unit of account, the dollar, is stabilized.

"Nothing is more important for a government to do for its citizens economically," he said, "than to provide them with a reliable unit of account, to keep track of their production and their wealth; plan for their retirement, their future and for their children's college educations."

During the Seventies, the dollar was unhinged from real values, from gold, said Wanniski. He said his mentor predicted in 1969 this experience would be so painful to the world economy because of the soaring world inflation it would cause, that by 1980 the world would move back to rehinging the paper currency to the value.

"We've had terrible world inflation," Wanniski reminded his audience as proof. "And now we're in the process of correcting those errors."

The job now, he said, is to move to rebuild the international monetary system. That is what has been happening so far this year, he said.

"There are only two ways you can bring down the interest rates," he said. " — increase the supply of credit or increase the demand for credit. We must make crediting more attractive to creditors, then the interest rate will come down."

The problem now in the US economy he said, is that the Reagan Administration has not gone to the second phase of the supply side economics program — to fixing the unit of account. But he said he is very optimistic; and predicted that early next year the first movement toward gold will occur.

"It will just take Reagan's call to the Treasury Department, to stabilize the price of gold. That will take all the risk out of the market, there will be an immediate decline in interest rates, and the rest of the world will follow.

"We have a few more hurdles to get over, but attention is shifting to monetary policy."

'You must speak out"

In other discussions at the conference, MSMS Legal Counsel William Sankbeil discussed his insights into the two and a half year old litigation between MSMS and the Federal Trade Commission.

(MSMS is now awaiting an appeal of an FTC administrative law judge's decision that MSMS fixed prices and restrained competition in dealings with Blue Cross Blue Shield of Michigan during the past five years.)

"The law is very unsettled on application of antitrust principles to health care. And when that is so, it provides many people with the opportunity to attack the profession," said Mr. Sankbeil.

It is his belief, Mr. Sankbeil said, that the FTC's actions often are motivated by political and social beliefs, rather than strictly legal principles. "They wish to force social change the way they think it should be, rather than according to what the law says."

"It is the FTC view that medical entrepreneurs must act individually and cannot discuss reimbursement issues with third party carriers."

"Third party carriers want to address physicians as a group. And when you superimpose the cost containment hue and cry, the situation becomes more bizarre."

Many government officials believe when these issues are addressed by physicians as a group it is only to tamper and fix prices, he said.

"I believe government should look at the entire picture, allow everyone to discuss the issues, and solve the major problems."

MSMS legal counsel's basic position is that the situation should be reviewed in its entirety, and that the FTC order, if allowed to stand, should at most only enjoin MSMS from boycotting BCBSM, he said. "We are fearful that if the order is entered, you may only speak as individuals. We are more fearful, knowing the FTC staff and the way this thing is written, that the order may be used to fulfill the perceived needs of the FTC staff."

Mr. Sankbeil called on the medical leaders present to make their views known through political action and public relations, to tell the public what physicians really want and what their goals are.

"You must speak out on issues."

Other speakers at the conference were:

AMA Trustee John J. Coury, MD, Port Huron, who described the AMA's reorganization and other priority programs today and called for physician unity;

MSMS President James D. Fryfogle, MD, Southfield, who welcomed the audience;

MSMS Council Chairman Thomas R. Berglund, MD, who outlined MSMS action programs;

Ruth Gattman, North Central Regional Legislative Chairman, AMA Auxiliary, who described a highly-successful, state-wide Voluntary Effort in Indiana, her home state;

Robert B. Carbeck, MD, Ann Arbor, who related the work of the Graduate Medical Education National Advisory Commission and its impact;

Past AMA President Edward Annis, Miami, FL, who brought a stirring challenge to Michigan physicians to act as national leaders.

Does the rise in the prime rate cause a rise in your blood pressure?

International Diamond Corporation
offers fine diamonds, a safe and secure asset for the '80s.

The 1980s promise to be a time of financial insecurity, high inflation, up-and-down gold prices and stock market instability. Only investment quality diamonds offer investors a steady, nonvolatile way to store wealth and increase your investment value.

International Diamond Corporation, the leader in investment diamond services, protects your investment safely and securely with:

- Insured grade accuracy, guaranteed in writing
- 10-year history of successful liquidations (resales)
- Audited records of profits to our customers
- Up-to-date computerized market reports
- The IDC "diamond banking" service, including the exclusive IDC Passbook Account to record your diamond acquisitions

Please contact one of our District Managers in your area to learn more about "diamond banking."

Armand Dion,	Flint	313-232-4470
John Burns,	Troy	313-588-7730
Richard Foster,	Adrian	517-265-3530
Paul French,	Three Rivers	616-273-9537
Roger Jones,	Lansing	517-323-7314
Dan Junttila,	Calumet	906-337-0500
Arnie Peterson,	Calumet	906-337-0500
Bernie Sementelli,	Flint	313-232-6820
Fred Berkman,	Bay City	517-893-9243
Ray McDermett,	Traverse City	616-941-4585
Bob Stritzinger,	Grand Rapids	616-459-2863

MICHIGAN REGIONAL HEADQUARTERS
James A. Fannon, 2120 - 44th Street, S.E., Grand Rapids, MI 49508 616-455-4310

International Diamond Corporation

Which retirement plan for you?

By David R. Nadeau
Grand Rapids

Which of the several plans to assure a good income at retirement is the best for you? Perhaps some straightforward information will help you decide. The IRS categorizes qualified retirement plans into two major groups: defined contribution plans and defined benefit plans. The primary difference between the two, as their names indicate, is whether the emphasis is on the annual current contribution or on the annual benefit at retirement.

There are several types of defined contribution plans, including profit-sharing, money-purchase and target-benefit plans. In this article, we will limit our discussion to profit-sharing plans.

A profit-sharing plan is characterized by several key features. These include:

- Individual participant accounts
- Variable contribution amounts
- Allocation of contributions
- Reallocation of forfeited amounts

Each participant in a profit-sharing plan has an individual account established to which employer contributions, investment gains and losses, and forfeitures are allocated.

The balance in this account at the participant's eventual retirement is used to provide retirement income. The plan administrator is responsible for maintaining the records of each individual account and for preparing the annual allocation of contributions.

Contributions to a profit-sharing plan must be made from the current or accumulated profits of the corporation, with the maximum contribution limited to 15 percent of the participant's compensation. Generally, the amount of contribution is established annually by the board of directors and can range from zero to 15 percent of compensation. However, because IRS regulations require that the contributions be "substantial and recurring," the flexibility of contributions is not as great as it might appear. A contribution of less than 15 percent of compensation will result in a "credit carryover" to succeeding years. The upper limit on contributions and deductions in any year, including carryovers, is 25 percent of compensation.

Once the contribution has been made to the plan, it must be allocated to each participant's account according to a predetermined formula. The most common allocation formula is based on the ratio of each individual's compensation to total compensation.

For example, if an individual's compensation is $10,000 and the total for all participants is $200,000, he would receive $10,000/$200,000 or 5 percent of whatever contribution is made.

One alternative formula is based on points, with one point awarded for each $100 of pay and one point awarded for each year of employment. The ratio of each participant's points to the total points is then applied to the total contribution.

Other methods of allocating contributions can be used by integrating the plan with Social Security benefits. This topic, however, will be covered separately in a later article. Investment gains and losses are normally allocated to the participants on the basis of their account balance at the beginning of the year. It is also acceptable to use an average of the beginning balance and the ending balance for this purpose.

When a participant's employment is terminated, there is usually a distribution of the "vested" amount of his account balance. The vested percentage is stated in the plan document and must meet certain IRS rules. The percentage of the account balance that is not vested is called a forfeiture and is reallocated to the other participants. This is usually done by applying the same formula as is used for allocating the corporate contribution.

The IRS also controls by regulation the maximum amount that can be allocated to any one individual account during the year. The current limitation for this purpose is $41,500 or 25 percent of compensation, whichever is less. This limit applies to the corporate contribution plus any forfeiture reallocations. For example, if a principal in a corporation had income of $300,000 during 1981, he would be limited to a total addition to his account of $41,500 or 13.8 percent of compensation. If there were forfeitures allocated to his account, the corporation could contribute only the difference between $41,500 and the amount of forfeitures. This dollar limit is increased annually by the IRS based on cost of living increases during the preceding year.

In summary, a profit sharing plan (by itself) will permit a principal in a corporation to shelter 15 percent of compensation, with a current annual maximum dollar limit of $41,500. The primary appeal of this type of plan is the flexibility in the amount of the contribution. In addition, there is no need for actuarial services and the administrative burden is relatively small. The major drawback is that 15 percent of compensation may not be a sufficient contribution to generate the required level of benefits at retirement. Professional advice should always be sought before deciding to establish a retirement plan. This is important not only to assure that the plan is qualified under the law, but also to be sure that the plan meets the goal of the plan sponsor.

In subsequent articles we will discuss other types of retirement plans.

Mr. Nadeau is a senior consultant with Watkins, Ross, Baines, & Lamps Inc., an actuarial and employee benefit consulting firm with offices in Grand Rapids and Detroit. A Certified Employee Benefit Specialist and a member of the Midwest Pension Conference, Mr. Nadeau has over six years experience in the employee benefit area in both the government and private sectors.

MSMS committees make things happen

The following brief statements regarding committees are not official purposes of the committees. They are intended as "thumbnail" descriptions for the general information of MSMS members. Official purposes of the committees are on file at MSMS headquarters.

Advisory to Bureau of Economics

The Advisory Committee assists the Bureau in setting priorities, studies current health care financing, makes specific recommendations concerning future financing mechanisms, and develops an understanding of traditional insurance companies, emerging alternative financing and health delivery systems.

Jay K. Harness, MD, Chairman, Chelsea
Gilbert B. Bluhm, MD, Southfield
John B. Bryan, MD, Royal Oak
Frank E. Check, Jr., MD, Detroit
Stuart L. Cohn, MD, Alpena
Donald K. Crandall, MD, Muskegon
Robert H. Hamburg, MD, Detroit
Margaret E. Jones, MD, East Lansing
Henry A. Kallet, MD, Chelsea
Philip F. Lange, MD, Lansing
Max L. Lichter, MD, Melvindale
John P. Papp, MD, Grand Rapids
Beverly C. Payne, MD, Ann Arbor
Thomas E. Stone, MD, Muskegon
Floyd S. Tukel, MD, Dearborn
Allen W. Turcke, MD, Flint
Frederick W. VanDuyne, MD, Flint
Senator Edward C. Pierce, Guest
John A. Richards, Staff Assistant

Advisory Task Force for MSMS Annual Scientific Meeting

This Task Force, under the guidance of the Committee on CME Programming, plans and presents Category I Credit courses at the Annual Scientific Meeting. It provides CME courses of value to all specialties while striving to improve methods of education and evaluation.

Frank Cox, Jr., MD, Chairman, Detroit
Denis F. Cash, MD, Flint
Edward Cotton, MD, Marcellus
Robert F. Johnson, MD, Grand Rapids
Kenneth L. Krabbenhoft, MD, Detroit
David R. Rovner, MD, East Lansing
Joan C. Stryker, MD, Detroit
Herbert A. Auer, Consultant, East Lansing
Sherry L. Fent, Staff Assistant

Aging

This Committee examines the status of senior citizens and advocates good health, preventive medicine programs, and adequate care for those who survive longer because of ad-

Continued on page 666

U.S. ARMY MEDICAL CAREER OPPORTUNITIES

We are looking for physicians who want to be physicians. We offer a practice that's practically perfect, where you work without worrying whether the patient can pay, without endless insurance forms, malpractice premiums, and cash flow worries, and where you prescribe, not the least care, not the defensive, but the best. If that is what you want, join the physicians who have joined the Army. Write us or call collect for the following information. We can offer:

Specialty Assignments
Residencies
Fellowships
Internships
Health Professions Scholarships
Employment Opportunities

Captain Gerard Indrisano
AMEDD Procurement Office
Federal Bldg.
200 E. Liberty St.
Ann Arbor, Mi 48107
(313) 668-2190

vances in medicine. It strives to revitalize local committees on aging.

William T. Bateman, MD, Chairman, Kalamazoo
Harvey M. Andre, MD, Grand Rapids
Michael Fleming, MD, Houghton
Edward J. Linkner, MD, Ann Arbor
Timothy J. Tobolic, MD, Byron Center
Russell Holmes, MD, Consultant, Lansing
Kevin A. Kelly, Staff Assistant

Steering Committee on Program to Assist Impaired Physicians

The Steering Committee provides assistance to physicians who have problems related to emotional illness, alcoholism, or drug abuse. Education toward prevention, case finding, and intervention are major components of the program.

John R. Ylvisaker, MD, Chairman, Bloomfield Hills
Robert H. Hydrick, MD, Grand Rapids
Stephen C. Mason, III, MD, Ann Arbor
Douglas A. Sargent, MD, Grosse Pte. Farms
Ward M. Smathers, MD, Lathrup Village
Justin L. Sleight, MD, Lansing
Russell F. Smith, MD, Whitmore Lake
Marcelyn Ireland, Staff Assistant

Advisory Committee on Federal Trade Commission

This Committee oversees and monitors every aspect of the current FTC litigation and provides guidance to staff, legal counsel, and MSMS.

Louis R. Zako, MD, Chairman, Dearborn Heights
A. Stewart Kerr, Detroit
W. E. Maldonado, MD, Lansing
Richard L. Rapport, MD, Flint
Donald N. Sweeny, Jr., MD, East Detroit
John R. Ylvisaker, MD, Bloomfield Hills
William E. Madigan, Staff Assistant

Awards

This Committee supervises the MSMS award programs and makes recommendations to the Council.

Justin L. Sleight, MD, Chairman, Lansing
Robert M. Leitch, MD, Battle Creek
Frank B. Walker, MD, Grosse Pte. Farms
Katie Brewbaker, Staff Assistant

Board of Directors, Physician Service Group, Inc.

Leland E. Holly, II, MD, Chairman, Muskegon
Frederick W. Bryant, MD, Royal Oak
James C. Danforth, Jr., MD, Grosse Pte. Woods
Jay K. Harness, MD, Chelsea
W. E. Maldonado, MD, Lansing
Allen F. Turcke, MD, Flint
Warren F. Tryloff, East Lansing
A. Stewart Kerr, Detroit
John H. Anthony, Staff Assistant

Board of Managers, MSMS

Leland E. Holly, II, MD, Chairman, Muskegon
Dean P. Carron, MD, Ann Arbor
Richard J. McMurray, MD, Flint
C. Allen Payne, MD, Grand Rapids
David Siegel, MD, Lansing
Arthur A. Ulmer, MD, Grosse Pte. Shores
Richard M. Campau, Staff Assistant

Claims Form and Uniform Code

This Committee monitors the development and implementation of the uniform claims form and coding system for third party payors in Michigan. It represents MSMS in working toward conversion to the national claims processing system mandated by federal law, and facilitates the implementation of new procedure codes approved by specialty societies.

John B. Bryan, MD, Chairman, Royal Oak
Frederick W. Bryant, MD, Royal Oak
John A. Richards, Staff Assistant

Constitution and Bylaws

This standing Committee reviews proposals to amend the MSMS Constitution and Bylaws and presents recommendations for appropriate action by the MSMS House of Delegates. It serves as a reference committee during the House of Delegates meetings.

Earl G. Moehn, MD, Chairman Mt. Clemens
Thomas F. Downham, II, MD, Taylor
James M. Grost, MD, St. Johns
John W. Hall, MD, Petoskey
James E. McGillicuddy, MD, Lansing
John J. McLaughlin, MD, Birmingham
B. David Wilson, MD, Kalamazoo
A. Stewart Kerr, Consultant
Warren F. Tryloff, Consultant
Vada L. Davis, Staff Assistant

Continuing Medical Education Accreditation

This Committee maintains standards to assure that quality CME activities

Continued on page 668

Fact:

One out of ten drinkers is an alcoholic.

The important fact to remember is that alcoholism, when properly treated, can be arrested. Our primary goal at Insight is to help people understand and deal effectively with their alcoholism — through intensive, short-term therapy in a residential setting and a planned aftercare program involving families, employers, A.A. and other significant support groups.

For more information, call or write:

INSIGHT AT COLOMBIERE
9075 BIG LAKE ROAD, POST OFFICE BOX 258
CLARKSTON, MI 48016, TELEPHONE (313) 625-0400

JCAH ACCREDITED
A PROGRAM OF INSIGHT INC

Put us to the test.

Send us a split specimen—at our expense—we'll prove our accuracy.

First, establish an account with us. It won't cost you anything. Then at your convenience, draw a specimen using accepted procedures. Divide it and submit it under two names. When you receive the results, and you're satisfied they're statistically parallel, call us. We'll credit your account. It's that simple.

What else can you expect?

Quick results. We have three strategically located labs to provide routine test results within 24 hours, tissue results within 48 hours. Plus STAT service on some procedures.

Pickup and mail service. In many areas, our trained couriers will pick up your specimens. Outside our wide service areas, we provide prepaid mailing containers.

Quick-scan highlighted reports. Our reports were designed by pathologists. Abnormals are highlighted, making them easy to spot.

Staff pathologists. Abnormals are reviewed daily by our full-time staff pathologists. Any significant abnormal is immediately retested at no charge and the confirmed results phoned to you. Of course, our pathologists are available for consultation at any time.

Serum retention program. To make it easier for both you and your patient, every serum specimen is frozen for one week after initial testing. If further testing is necessary, just call us.

Accuracy assistance. We can assist you in training your personnel in laboratory procedures and proper specimen handling. Proper collection, handling and submission at your end further ensures accuracy at ours.

We're CBC and we've got a lot more to offer you. Our service is comprehensive, convenient, fast, and most important . . . accurate. Take the time to take our test. It may be one of the best things you ever do for your patients. And we *can* prove it.

To put us to the test call:
1-800-632-0706.

CBC CONTINENTAL
BIO-CLINICAL
LABORATORY SERVICE, INC.
Grand Rapids, Michigan • Toledo, Ohio
Mishawaka, Indiana

Do you know

a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?

If so, please contact
your MSMS Committee to
Assist Impaired Physicians
through Marce Ireland at MSMS
headquarters (517) 337-1351

are available to Michigan physicians, through review, evaluation, and accreditation of continuing medical education providers in the state.

Donald J. Aiken, MD, Chairman, Okemos
Richard F. Willis, MD, Vice Chairman, Alpena
Philip Adler, DO, Farmington
Gail I. Bank, PhD, Detroit
James C. Breneman, MD, Galesburg
Laurence Bruggers, MD, Saginaw
Allen D. Damschroder, MD, Petoskey
Alfred Ellison, MD, Lansing
Roland G. Hiss, MD, Ann Arbor
James J. Humes, MD, Detroit
John W. Moynihan, MD, Dearborn
Richard W. Pomeroy, MD, Okemos
Michael Radke, PhD, Lansing
Robert K. Richards, PhD, Grand Rapids
Joseph A. Sentkeresty, MD, Grand Rapids
Marvin Sherman, MD, Farmington
Robert L. Tupper, MD, Grand Rapids
Charles L. Zeller, Jr., MD, Kalamazoo
Marcelyn Ireland, Staff Assistant

Continuing Medical Education Programming

The Committee develops, conducts, and supervises Category I programs in Michigan to serve the continuing medical education needs and interests of physicians. It also is empowered to co-sponsor programs which meet the criteria for Category I programs.

Samuel M. McMahon, MD, Chairman, Lansing
John R. Addy, MD, Lansing
Frederick W. Bryant, MD, Royal Oak
Merle A. Childers, MD, Rochester
Edward Cotton, MD, Marcellus
Frank Cox, Jr., MD, Detroit
Clyde R. Flory, Jr., MD, Lansing
Gerald B. Holzman, MD, East Lansing
Rodman C. Jacobi, MD, East Lansing
Richard A. Lemmer, MD, Kalamazoo
Linda J. Logsdon, MD, Southfield
Kenneth H. Musson, MD, Traverse City
Joan C. Stryker, MD, Wyandotte
Herbert A. Auer, Advisor, Ypsilanti
Ray E. Yeater, Advisor, Ypsilanti
Sherry L. Fent, Staff Assistant

Judicial Commission

The Commission has sole jurisdiction over matters of ethics, mediation, grievance, and discipline of MSMS members. It has authority to make binding interpretations of the MSMS Constitution and Bylaws and of component society bylaws, as well as rules and regulations governing such matters.

Harold A. Machin, MD, Chairman, Kalamazoo
William C. Baum, MD, Holland
Edwin R. Guise, MD, Detroit
Raymond C. Husband, MD, Detroit
Charles N. Inniss, MD, Detroit
Adam C. McClay, MD, Traverse City
John H. McLaughlin, MD, Birmingham
Richard J. McMurray, MD, Flint
Joseph L. Ponka, MD, Detroit
George D. Stilwill, MD, Lansing
A. Stewart Kerr, Consultant, Detroit
Vada L. Davis, Staff Assistant

Liaison Committee with Auxiliary

The Liaison Committee advises the MSMS Auxiliary on request, regarding Auxiliary activities and problems. It also suggests projects the Auxiliary may wish to undertake.

R. Jack Chase, MD, Chairman, Grand Rapids
Dean P. Carron, MD, Ann Arbor
Lawrence E. Grennan, MD, Muskegon
John R. Ylvisaker, MD, Bloomfield Hills
Fikria B. Hassan, MD, Advisor, Flint
Caroline A. Rich, Staff Assistant

Liaison Committee with Medical Assistants

The Liaison Committee advises the American Association of Medical Assistants, State of Michigan, on request regarding medical assistants activities and problems. It also suggests projects the medical assistants may wish to undertake.

Continued on page 670

Other Companies Throw In The

Much Too Soon.

We don't.

We believe you want service for your professional liability premium dollars. And that's what you get from MPMLC. Service.

Our occurrence coverage states that we won't settle a claim without your consent. We back that up with an expert team of physicians, defense attorneys, and claims representatives who have the reputation of being tough on non-meritorious suits.

Maybe you won't use our services this year. Most physicians hope they never have to go through the emotional trauma of a professional liability claim.

But statistically that hope is fading. In Michigan, multi-million dollar lawsuits and frequent claims against physicians are on the upswing.

To learn how you can join Michigan's fastest growing physician insurance company, call or write Jim Zwada, Vice President, Marketing, for a special information package about MPMLC.

Michigan Physicians
Mutual Liability Company

Home Office—1305 Abbott Road • East Lansing, MI 48823 • (517) 351-1150 • (800) 292-1926
Satellite Office—6735 Telegraph Road, Suite 205 • Birmingham, MI 48010 • (313) 647-5550

David W. Hills, MD, Chairman, St. Joseph
Donald L. Baltz, MD, Dearborn
Darwin J. Beldon, MD, Detroit
Harold H. Neikamp, MD, Jackson
James R. Quinn, MD, Pontiac
Joseph J. Tiziani, MD, Ann Arbor
Thomas R. Berglund, MD, Council Advisor, Kalamazoo
Caroline A. Rich, Staff Assistant

Federal Legislation and Related Matters

This one-man Committee works in cooperation with the Washington, DC, office of the American Medical Association.

Richard J. McMurray, MD, Chairman, Flint
Bruce W. Ambrose, Staff Assistant

MSMS Member Benefit Programs

This Task Force evaluates existing and proposed health and dental insurance programs and other benefits for MSMS members, families, and employees and reports its findings and recommendations to The Council for action.

Donald G. Blain, MD, Chairman, Mt. Clemens
John G. Bielawski, MD, Dearborn
Ernest P. Griffin, Jr., MD, Flint
Robert J. Toteff, MD, Saginaw
William B. Cheeseman, Consultant, East Lansing
Gae Ellery, BCBSM Consultant, Detroit
Wayne E. Burnmeister, Staff Assistant

Steering Committee on Health Planning

This Committee recommends MSMS policy on health planning. It encourages physician involvement in health planning issues, monitors activities of health systems agencies (HSA) and the Statewide Health Coordinating Council (SHCC) and assures physician input.

Kenneth J. Ray, MD, Chairman, Trenton
Billy B. Baumann, MD, Pontiac
James D. Fryfogle, MD, Southfield
George R. Gerber, MD, Rochester
George H. Greidinger, MD, Flint
Jerold Harwood, MD, Traverse City
D. Bonta Hiscoe, MD, Lansing
Richard J. Potter, MD, Grand Rapids
Charles L. Seifert, MD, Battle Creek
Robert J. Toteff, MD, Saginaw
Robert J. Tupper, MD, Grand Rapids
Theodore S. Vanderveen, MD, Grand Haven
Ian D. Wilson, MD, Petoskey
Roger W. Mecum, Advisor, Detroit
Hermann A. Ziel, Jr., MD, Consultant, Lansing
Dennis M. Paradis, Staff Assistant

Continued on page 672

Microbiological Systems for the Physician's Office

- Troy Biologicals offers a variety of culture systems that enable the physician to perform a culture and sensitivity on different specimens (throat, urine, vaginal, wound, skin, etc.).
- *The Quad Plus System* is an all purpose system which includes a (1) quad plate for identification purposes, (2) a Mueller Hinton plate for sensitivity testing, (3) antibiotic discs, (4) swabs and (5) patient report pads. Pricing for the *Quad Plus System* begins at $1.99 per system. Quantity discounts are available.
- Specialized bi-plate and tri-plate systems are also available for throat and urine specimens. Troy Biologicals also offers a complete line of standard plates and tubed media, such as T.S.A. with 5% sheep's blood, E.M.B. agar, MacConkey agar, etc. Contact us for a price quote.
- A complete set-up is available upon request. Troy Biologicals carries a full line of related microbiological supplies such as incubators, loops, alcohol lamps, swabs, culturettes, disc dispensers, etc.
- A *Workshop in Clinical Microbiology* is also available to those who need additional training.
- Call for a complete price list and colored brochure.

TROY BIOLOGICALS, INC.
6107 E. Ten Mile Road • Warren, Michigan 48091
Call Collect: (313) 759-4530

COMMERCIAL CREDIT EQUIPMENT CORP.
McCULLAGH LEASING, INC.

30855 Little Mack Avenue
Roseville, Michigan 48066
(313) 296-4200

Dear Doctor:

We at McCullagh Leasing, Inc. want to thank you for your acceptance of the car leasing concept and your trust and confidence in our staff.

Since 1971, we have endeavored to give Michigan State Medical Society and its members an exclusive lease program at the same low rates as a large fleet user.

Leasing acts as a hedge against inflation because tomorrow's costs are paid with tomorrow's dollars.

Once again, thank you for your continued confidence and participations.

Sincerely,

McCullagh Leasing, Inc.

a financial service of
CONTROL DATA CORPORATION

Humanitarian Services

This Committee identifies areas where MSMS may use its influence at the state, national, or international level to improve the public's health and increases the awareness of MSMS membership about current humanitarian services involving members of organized medicine.

James H. Tisdel, MD, Chairman, Port Huron
Brooker L. Masters, MD, Fremont
John R. Ylvisaker, MD, Bloomfield Hills
Dennis M. Paradis, Staff Assistant

Task Force to Improve Component Society Relations

This Task Force seeks to improve working, cooperative relationships with components, their officers and executives, by encouraging or developing visitation programs, by involvement in special seminars or through special program segments of the MSMS Public Affairs/Leadership Conference. It also determines components' needs and makes recommendations to The Council for fulfilling those needs.

James H. Tisdel, MD, Chairman, Port Huron
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
Robert J. Toteff, MD, Saginaw
William E. Madigan, Staff Assistant

Liaison Committee with Michigan Department of Public Health

The Committee works to improve information and communication channels among public health officers, practicing physicians, and the public on public and environmental health issues of mutual concern.

Richard H. Gascoigne, MD, Chairman, Adrian
E.Joseph Alberding, MD, Portage
Carl A. Gagliardi, MD, Lincoln Park
Robert P. Locey, MD, Pontiac
Francis L. Purcell, MD, Ypsilanti
Norman L. Welch, MD, Muskegon
Bailus Walker, Jr., PhD, MDPH Director, Lansing
Sherry N. Wellman, Staff Assistant

Committee on Maternal and Perinatal Health

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal and perinatal health to discuss mutual problems and share ideas. It works in close cooperation with state agencies and medical specialty organizations.

Lee B. Stevenson, MD, Chairman, Southfield
Hermann A. Ziel, Jr., MD, Vice Chairman, Lansing
Mohammed Ali Aussie, MD, Lathrup Village
Robert J. Austin, MD, Kalamazoo
Robert C. Borer, MD, Detroit
C. Arch Brown, MD, Flint
Laurence Bruggers, MD, Saginaw
Joseph A. Caruso, MD, Lansing
John R. Cooley, MD, Kalamazoo
Miriam S. Daly, MD, Albion
Robert W. Dustin, MD, Dearborn
James W. Gell, MD, Bloomfield Hills
Alan D. Goldsmith, MD, Southfield
John W. Hallitt, MD, Flint
John V. Hartline, MD, Kalamazoo
Gerald B. Holzman, MD, East Lansing
James R. Irwin, MD, Grand Rapids
Lloyd A. Kammeraad, MD, Grand Rapids
Thomas Kirschbaum, MD, East Lansing
Mary J. Kokosky, MD, Dearborn
James G. Kornmesser, MD, Farmington Hills
Donald R. Krohn, MD, Farmington Hills
Chang Y. Lee, MD, Detroit
William A. LeMire, III, MD, Escanaba
Francis A. Locke, MD, Adrian
Federico G. Mariona, MD, Detroit
Joseph S. Moore, MD, Grand Rapids
Wallace G. Pearson, MD, Marquette
Ronald L. Poland, MD, Detroit
Dorothy A. Porter, MD, Lathrup Village
Jack R. Postle, MD, Petoskey
Roger W. Postmus, MD, Ann Arbor
Charles H. Sander, MD, East Lansing
James W. Sharpe, MD, Port Huron
Joseph L. Sheets, MD, Lansing
Carolyn Texera, MD, Lansing
James H. Tisdel, MD, Port Huron
Arthur A. Ulmer, MD, Grosse Pte. Shores
William T. Unkefer, MD, Farmington Hills
Andrew Veldhuis, MD, Mt. Pleasant
Howard R. Williams, MD, Cedarville
Mason Barr, Jr., MD, Consultant, Ann Arbor
John W. Goldkrand, MD, Consultant, Detroit
Philip J. Howard, MD, Consultant, Clarendon, VT
Eugene V. Perrin, MD, Consultant, Detroit
Joseph Walczak, DO, Consultant, East Lansing
Mary M. Conklin, RN, Advisor, Lansing
Mary A. Scoblic, RN, Advisor, Lansing
Jeffrey Taylor, PhD, Advisor, Lansing
Goldie Corneliuson, MD, Honorary Member, Fort Meyers, FL
James E. Harryman, MD, Honorary Member, Muskegon
Francis A. Jones, MD, Honorary Member, Vero Beach, FL
Norman F. Miller, MD, Honorary Member, Florence, WI
Helen A. Schulte, Honorary Member DeWitt
Charles S. Stevenson, MD, Honorary Member, Center Sandwich, NH
Katie Brewbaker, Staff Assistant

Medicaid Liaison Committee

The Liaison Committee attempts to resolve individual physicians' problems with Medicaid payments and procedures, and discusses major policy issues of the Medicaid program with state government.

Allen F. Turcke, MD, Chairman, Flint
John W. Coles, MD, Mt. Pleasant
Thomas M. Flake, MD, Detroit
James D. Johnston, MD, Traverse City
Cecil R. Jonas, MD, Detroit
Henry A. Kallet, MD, Chelsea
John L. Loomis, MD, River Rouge
Gerald H. Mandell, MD, Detroit
Robert J. Toteff, MD, Saginaw
Sherry N. Wellman, Staff Assistant

Task Force on Medical Care Costs

The Task Force considers and evaluates methodologies for containing the cost of quality health care, encourages cost awareness, and develops practical guides for hospital medical staffs. It interfaces with the BCBSM Regional Cost Committees, acts as a liaison committee to physicians serving on these committees and reviews cost containment initiatives by the RCCs.

R. Jack Chase, MD, Chairman, Grand Rapids
Robert W. Black, MD, Detroit
Robert H. Hamburg, MD, Detroit
Louis E. Heideman, MD, Birmingham
Ronald L. Krome, MD, Detroit
John H. Libcke, MD, Pontiac
Gerald H. Mandell, MD, Detroit
Sheldon F. Markel, MD, Ann Arbor
James E. McGillicuddy, MD, Lansing
E. James Potchen, MD, East Lansing
James A. Read, MD, Birmingham
Frederick W. VanDuyne, MD, Flint
Charles R. Zimont, MD, Constantine
Deborah Zannoth, Staff Assistant

Medical Education Policy

This Committee studies the broad issues involving medical education on the undergraduate, graduate, and postgraduate levels, complementing the work of the MSMS Committees on CME Programming and CME Accreditation. It also reviews issues pertaining to paraprofessional education and scope of practice.

Charles C. Vincent, MD, Chairman, Detroit
Samuel M. McMahon, MD, Lansing
Richard W. Pomeroy, MD, Okemos
E. James Potchen, MD, East Lansing
James A. Read, Birmingham
Marsha M. Rohrer, MD, Lansing
J. Robert Willson, MD, Ann Arbor
Herbert A. Auer, Staff Assistant
Katie Brewbaker, Staff Assistant

Task Force on Medical Fraud and Abuse

The Task Force strives to assist the State of Michigan and third party payors in developing programs to counter illegal or unethical activities in the health care system. It also identifies areas of the medical system where there is a high potential for abuse and recommends possible methods of prevention.

Gerald H. Mandell, MD, Chairman, Detroit
William S. Carpenter, MD, Detroit
Edward E. Elder, MD, Pontiac
Robert H. Hamburg, MD, Detroit
Charles O. Long, MD, Lansing
Richard L. Rapport, MD, Flint
John A. Richards, Staff Assistant

Medical Staff Relations

This Committee is working to develop a specific mechanism for interacting with hospital medical staffs and to strengthen and enhance the mutual communications of MSMS and its medical staff leader members.

Gary D. Maynard, MD, Chairman, Kalamazoo
Robert W. Black, MD, Detroit
Richard D. Hackley, MD, Flint

Michigan Delegation to the AMA

Delegates

Robert D. Allaben, MD, Detroit
Thomas R. Berglund, MD, Portage
Robert D. Burton, MD, Grand Rapids
Donald K. Crandall, MD, Muskegon
Richard J. McMurray, MD, Flint
David Siegel, MD, Lansing
Donald N. Sweeny, Jr., MD, Detroit
Frank B. Walker, MD, Grosse Pointe Farms

Alternate Delegates

George M. Wilson, MD, Marquette
Richard H. Gascoigne, MD, Adrian
Gerald H. Mandell, MD, Detroit
Carl A. Gagliardi, MD, Dearborn
Louis R. Zako, MD, Dearborn Heights
Jay K. Harness, MD, Chelsea
Billy Ben Baumann, MD, Pontiac
Robert E. Paxton, MD, Fremont

Statement of ownership, management and circulation

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management, and Circulation of *Michigan Medicine*, published three times per month, 36 issues, mailed at East Lansing, Michigan and additional post offices in Ingham County for December 1, 1981.

1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan, 48823.

2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

3. The publisher is the Michigan State Medical Society. The editor is Judith E. Marr, 120 West Saginaw Street, East Lansing, Michigan 48823.

4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

5. The known bondholders, mortgagees and other holders owning or holding one percent or more of total amount of bonds, mortgages, or other securities are: None.

6. A. The total number of copies printed averages 9,154 per issue with a single issue nearest to filing date accounting for 9,150 copies.
   B. Paid circulation 8,754 subscriptions by mail, these being the active members of the Michigan State Medical Society, and others who receive subscriptions.
   C. Sales to dealers, number none.
   D. Free distribution by mail carrier or other means; 250.
   E. Total number of copies distributed is 9,004.

I certify that the statements made be me above are correct and complete.

Wellman Press, Inc.
For the Publisher

James J. Humes, MD, Detroit
Leonard H. Wolin, MD, Ann Arbor
William E. Madigan, Staff Assistant

Membership Recruitment and Retention

This Committee guides all recruitment efforts aimed at non-member physicians, residents, and students. It develops membership goals, makes recommendations to The Council and conducts personal recruiting efforts when needed.

Billy B. Baumann, MD, Chairman, Pontiac
Joseph A. Arends, MD, Troy
Dale R. Drew, MD, Pontiac
James J. Faremouth, MD, Mt. Clemens
Jay K. Harness, MD, Chelsea
John M. Murphy, MD, Port Huron
Louis R. Zako, MD, Dearborn Heights
Norman Anderson, Advisor, Flint
Sue Hoeflinger, Advisor, Birmingham
Roger Mecum, Advisor, Detroit
Mary Sue Meyer, Advisor, Birmingham
Pamela Papas, Student Advisor, Southfield
Tom Prose, Student Advisor, Detroit
Merwyn G. Scholten, Staff Assistant

Michigan State Medical Society/Michigan Hospital Association Liaison Committee

This formal liaison committee is composed of designated leaders of the two organizations. The liaison committee does not make policy for either organization; each organization refers any recommendations to the MSMS Council or MHA Board of Trustees for approval.

Thomas R. Berglund, MD, Chairman of The Council, Kalamazoo
James D. Fryfogle, MD, President, Southfield
James H. Tisdel, MD, President-Elect, Port Huron
John R. Ylvisaker, MD, Immediate Past-President, Bloomfield Hills
Warren F. Tryloff, Director, East Lansing
William E. Madigan, Staff Assistant

Planning Committee for 1982 Michigan Conference on Maternal and Perinatal Health

The Planning Committee, under the guidance of the MSMS Committee on Maternal and Perinatal Health, plans and implements a Category I CME program for the Annual Michigan Conference on Maternal and Perinatal Health, in cooperation with several other participating organizations. tions.

John W. Hallitt, MD, Co-chairman, Flint
Gerald B. Holzman, MD, Co-chairman, East Lansing
Robert C. Borer, Jr., MD, Detroit
C. Arch Brown, MD, Flint
Laurence Bruggers, MD, Saginaw
Mary M. Conklin, RN, Lansing
Miriam S. Daly, MD, Albion
Marianne R. Glassanos, RN, Ann Arbor
Joan Hall, RN, Grosse Pte.
John V. Hartline, MD, Kalamazoo
James V. Higgins, PhD, East Lansing
Mary J. Kokosky, MD, Dearborn
Gretchen Landenburger, MS, East Lansing
Federico Mariona, MD, Detroit
Dorothy A. Porter, MD, Lathrup Village
Mary A. Scoblic, RN, Lansing
Kenneth J. VanderKolk, MD, Grand Rapids
Donald Waterman, MD, Grand Rapids
Lester Weiss, MD, Detroit
William I. Young, PhD, Lansing
Henry L. Nadler, MD, Consultant, Detroit
Lee B. Stevenson, MD, ex-officio, Southfield
Katie Brewbaker, Staff Assistant

Planning Committee for Women Physicians Workshop

This Committee is planning a spring 1982 leadership workshop for women physicians to assist them in increasing their involvement in the leadership of organized medicine.

Linda J. Logsdon, MD, Chairperson, Southfield
Anna M. H. Broecker, MD, Grand Rapids
Miriam S. Daly, MD, Albion
Carl A. Gagliardi, MD, Dearborn
Vivian R. Lewis, MD, Flint
Louis R. Zako, MD, Dearborn Heights
Vada L. Davis, Staff Assistant

Task Force on Professional Liability

The Task Force reviews the professional liability climate in Michigan and the nation, becomes familiar with the professional liability terms and legislation, and recommends any appropriate legislation or alternative mechanisms to be used in Michigan.

Frederick V. Minkow, MD, Chairman, Bloomfield Hills
Thomas C. Payne, MD, East Lansing
Rhoda M. Powsner, MD, Ann Arbor
Kenneth J. Ray, MD, Trenton
James A. Read, MD, Birmingham
William B. Cheeseman, Consultant, East Lansing
William E. Madigan, Staff Assistant

Publications

This Committee serves as an advisory board to the editor in determining policy, setting new directions, suggesting subject material, overseeing finances, and reviewing all display advertising for MSMS publications.

Busharat Ahmad, MD, Chairman, Marquette
Harvey M. Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
John R. Ylvisaker, MD, Bloomfield Hills
Judith Marr, Staff Assistant

Public Service

This committee develops and oversees all public relations and public information activities. It provides physician input to the program suggestions and activities advanced by outside consultants and MSMS staff.

Robert D. Burton, MD, Chairman, Grand Rapids
Henry J. Barsch, MD, Marquette

Continued on page 676

There's a first time for everything.

When you buy your first medical computer system from us, we'll be there to hold your hand.

The MEDICAL PRACTICE MANAGEMENT SYSTEM© is designed to fit perfectly into solo and group practices and is completely compatible with the Michigan insurance environment.

MPMS is the first affordable medical computer system. Costing less than $200 per month, MPMS can more than pay for itself by;

- Increasing collections
- Reducing accounts receivable
- Increasing staff efficiency

MPMS takes care of your patient billing needs automatically by processing;

- Blue Cross & Blue Shield of Michigan
- Medicare and Medicaid
- Independent insurance claims
- Patient statements
- Cash and credit card transactions
- Collection letters

MPMS optionally, provides for "paperless" electronic billing of Blue Cross and Blue Shield of Michigan for more rapid claims processing.

MPMS gives you more control over your practice by creating;

- Daily and Monthly Transaction Reports
- Income Analysis by; Procedure, Location and Doctor
- General Ledger
- Balance Sheet and Income Statement
- Accounts Receivable Aging Report
- Open Insurance Claims Register
- Payroll and Accounts Payable

MPMS is extremely easy to use and we provide complete installation, training, local service and support.

Let us show you the benefits of our MEDICAL PRACTICE MANAGEMENT SYSTEM today by calling toll-free 1-(800) 292-4542 or (517) 351-7396 collect . . . or write for our brochure.

INFOMAX SYSTEMS, INC.
241 East Saginaw St., East Lansing, MI 48823
1-(800) 292-4542 or (517) 351-7396

COMMITTEES/*Continued*

Marshall Blondy, MD, Livonia
Mark G. Campbell, MD, Grand Rapids
Robert L. Cross, MD, Flushing
Clyde R. Flory, Jr., MD, Lansing
Richard H. Gascoigne, MD, Adrian
David W. Hills, MD, St. Joseph
William K. Howard, MD, Detroit
John L. Isbister, MD, Okemos
Sidney D. Kobernick, MD, Detroit
John H. Libcke, MD, Pontiac
Frederick J. Margolis, MD, Kalamazoo
Thomas C. Payne, MD, East Lansing
Richard R. Royer, MD, Detroit
Norman Anderson, Advisor, Flint
Mrs. S. A. Yannitelli, Advisor, Battle Creek
Merwyn G. Scholten, Staff Assistant

Review MSMS Policies

This committee was established by the 1981 House of Delegates to review current MSMS policies and present recommendations to The Council regarding continuation, revision, deletion, or addition of policies, with a final report to the 1982 MSMS House of Delegates.

Richard L. Rapport, MD, Chairman, Flint
John B. Bryan, MD, Royal Oak
Gerald F. Conway, MD, Royal Oak
Thomas M. Flake, MD, Detroit
Ernest P. Griffin, Jr., MD, Flint
John M. Malone, MD, Farmington Hills
James E. McGillicuddy, MD, Lansing
Richard J. McMurray, MD, Flint
Fred E. Patterson, MD, Ann Arbor
Rhoda M. Powsner, MD, Ann Arbor
Leonard H. Wolin, MD, Ann Arbor
Louis R. Zako, MD, Dearborn Heights
Grace Auer, Guest, East Lansing
Vada L. Davis, Staff Assistant

Specialty Society Presidents

This committee provides for rapid communication between MSMS and the members of specialty organizations. It deals with any subject of mutual concern except scientific or clinical medicine.

Louis R. Zako, MD, Chairman, Dearborn Heights
Michigan Allergy Society: Benjamin J. Stone, MD, East Lansing
Michigan Society of Anesthesiologists: Richard P. Horsch, MD, Farmington Hills
Michigan Chapter, American College of Chest Physicians: Agustin Arbulu, MD, Detroit
Michigan Section on Clinical Pharmacology: Walter M. Baird, MD, Lansing
Michigan Society of Colon and Rectal Surgeons: Rafael Quinones, MD, Troy
Michigan Dermatological Society: George R. Mikhail, MD, Royal Oak
Michigan Chapter, American College of Emergency Physicians: Robert M. Williams, MD, East Lansing
Michigan Academy of Family Physicians: John W. MacKenzie, MD, Swartz Creek
Michigan Society of Gastrointestinal Endoscopy: E. M. Barbour, MD, Dearborn
Michigan Society of General Surgeons: Michael N. Zelenock, MD, Southgate
Michigan Health Officers Association: Dean Tribby, DVM, Jackson
Michigan Society of Internal Medicine: Hector J. Inchaustegui, MD, Royal Oak
Michigan Neurological Society: Sheila Sheehan, MD, Detroit
Michigan Association of Neurological Surgeons: David Herz, MD, Grand Rapids
Michigan College of Nuclear Medicine Physicians: Howard J. Dworkin, MD, Royal Oak
Michigan Society of Obstetricians and Gynecologists: Bruce H. Drukker, MD, Detroit
Michigan Section, American College of Obstetricians and Gynecologists: Joseph J. Woods, MD, Southfield
Michigan Occupational Medical Association: Lucius C. Tripp, MD, Warren
Michigan Ophthalmological Society: David Barsky, MD, Wyandotte
Michigan Orthopaedic Society: Russell Cashen, MD, Kalamazoo
Michigan Oto-Laryngological Society: Dieter Wendling, MD, Mt. Clemens
Michigan Society of Pathologists: Frank B. Walker, MD, Grosse Pte. Farms
Michigan Chapter, American Academy of Pediatrics: Robert S. Holm, MD, Kalamazoo
Michigan Academy of Physical Medicine and Rehabilitation: Myron M. LaBan, MD, Royal Oak
Michigan Chapter, American College of Physicians: Boy Frame, MD, Detroit
Michigan Academy of Plastic Surgeons: W. Peter McCabe, MD, Grosse Pte. Woods
Michigan Psychiatric Society: Emanuel E. Tanay, MD, Detroit
Michigan Psychoanalytic Society: Melvin Bornstein, MD, Birmingham
Michigan Radiological Society: Robert A. Songe, MD, Dearborn
Michigan Chapter, American College of Surgeons: John H. McLaughlin, MD, Birmingham
Michigan Society of Therapeutic Radiologists: William E. Powers, MD, Detroit
Michigan Society of Thoracic Surgeons: Jack Hertzler, MD, Detroit
Michigan Branch, American Urological Association: Gerald F. Conway, MD, Royal Oak
William E. Madigan, Staff Assistant

Sports Medicine

This Committee sponsors the annual Sports Medicine Conference aimed at physicians and others with an interest in sports medicine. It also provides sports medicine information and medical evaluation of sports rules when requested by the Michigan High School Athletic Association, Inc.

Charles R. Zimont, MD, Chairman, Constantine
Edward M. Fugate, MD, Muskegon
Perry W. Greene, Jr., MD, Grand Rapids
Edwin R. Guise, MD, Detroit
Richard A. Lemmer, MD, Kalamazoo
Robert A. Lewis, MD, Sturgis
Robert C. Mahaney, MD, Holland
Robert J. Murray, MD, Trenton
Gerald A. O'Connor, MD, Ann Arbor
William B. Redmon, MD, Midland
Mike Abdenour, Advisor, Pontiac
Jack Jones, Advisor, Kalamazoo
Douglas B. McKeag, MD, Advisor, East Lansing
Russell Miller, Advisor, Ann Arbor
Vern L. Norris, Advisor, East Lansing

Continued on page 67

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, end physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinome of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administretion or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When **impotence** is due to androgenic deficiency.

Android®/5 Buccal mg./10 Oral mg./25 Oral mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Members must be 70 and retired for AMA dues-exempt status

Physicians must be 70 and retired to qualify for dues-exempt AMA membership under new AMA bylaws changes.

Physicians continue to qualify for dues-exempt AMA membership status if they are experiencing financial hardship or physical disability preventing active practice.

Reports U of the Board of Trustees and B of the Council on Constitution and Bylaws (A-81) were adopted by the House of Delegates at the 1981 Annual Meeting and as a result §1.1273 of the AMA Bylaws was amended. Report U of the Board of Trustees proposed a revision in AMA criteria for dues exemption to limit exemptions to those who are over the age of 70 and retired from practice and to those physicians experiencing financial hardship or physical disability preventing active practice. Report B of the Council on Constitution and Bylaws provided the necessary language to amend the dues exemption provisions of the Bylaws.

The previous dues exemption policy of the AMA was to accept as dues exempt those physicians recommended by the state societies under one of the following three classifications:

1. Financial hardship and disability
2. Retirement
3. Over age 70

Under those criteria, there was no age requirement in the retirement dues exempt classification.

Under the current amendment, the AMA Board of Trustees is responsible for establishing appropriate standards and procedures for the granting of all dues exemptions. *However, these standards will not be applied retroactively to existing dues exempt members.*

At its September 1981 meeting, the Board of Trustees approved new policies establishing the two new dues exemption categories.

The definition of "financial hardship and disability," consistent with the Bylaws, states that "the Board of Trustees may excuse members from payment of dues to alleviate financial hardship or because of forced retirement from medical practice due to physical disability."

The definition of "retired" is stated as a workload of 20 hours or less per week which is consistent with other data collection procedures of the AMA. Therefore, the retirement category by which physicians under the age of 70 are provided with dues exempt membership in the AMA has been eliminated.

In confirmation of the House action, the Board decision means that any active member who is now over the age of 70 and retired from the practice of medicine will not be required to pay dues to the AMA. Physicians who reach 70 years of age in 1981 or in subsequent years and are in active practice will be required to pay full regular dues. Physicians with questions may contact Lorna Wunderman, Director of the AMA Department of Membership Information Services, 312/751-5992.

COMMITTEES/*Continued*

Clinton Thompson, Advisor, East Lansing
Merwyn G. Scholten, Staff Assistant

State Legislation and Regulations

This Committee monitors and influences Michigan legislation through the legislative process, and monitors and responds to Michigan government rules and regulations as they are promulgated.

W. E. Maldonado, MD, Chairman, Lansing
Robert D. Allaben, MD, Detroit
Gordon Baustian, MD, Lansing
Carl G. Benner, MD, Traverse City
Michael T. Bergeon, MD, Saginaw
Robert D. Burton, MD, Grand Rapids
Gwendolyn D. Dennard, MD, Detroit
John A. Feemster, MD, Detroit
Richard P. Heuschele, MD, Saginaw
William H. Hoffman, MD, Detroit
Richard P. Horsch, MD, Farmington Hills
Van O. Keeler, MD, Otsego
James E. McGillicuddy, MD, Lansing
Frederick V. Minkow, MD, Bloomfield Hills
Charles L. Oppy, MD, Roscommon
Winifred A. Oyen, MD, Midland
Fred E. Patterson, MD, Ann Arbor
John C. Parker, MD, Jackson
Kianoosh Radsan, MD, Allen Park
Mitchell A. Rinek, MD, Lansing
Edward J. Rutkowski, MD, Traverse City
William T. Sallee, MD, Farmington
Lewis E. Simoni, MD, Flint
Marvin L. Starman, MD, Southfield
Willard S. Stawski, MD, Grand Rapids
Thomas E. Stone, MD, Muskegon
Franklin L. Troost, MD, Holt
Frank G. VanDeventer, MD, Harper Woods
William J. Venema, MD, Kalamazoo
Frank B. Walker, MD, Grosse Pte. Farms
Bernard J. Woodley, MD, Trenton
Mrs. William Jensen, Jr., East Grand Rapids
A. Stewart Kerr, Detroit
Roger Mecum, Detroit
Milton Zaagman, Lansing
Bruce W. Ambrose, Staff Assistant

Ways and Means

This committee furnishes cost estimates to the House of Delegates on all resolutions requiring expenditure of funds. It also reviews general fiscal policies of the society on behalf of the House of Delegates.

Richard J. McMurray, MD, Chairman, Flint
Emil J. Alberding, MD, Portage
Hector J. Inchaustegui, MD, Royal Oak
James L. Lovell, MD, Marquette
Timothy M. Talbott, MD, Grand Rapids
Leonard H. Wolin, MD, Ann Arbor
Richard M. Campau, Staff Assistant

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION

CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
143 Courtland Avenue
Rockford, Michigan 49341
(616) 866-9395

Administrative office and main laboratory

AMRC the full service laboratory

- Complete range of individual tests and diagnostic profiles
- Medical consultation services
- Comprehensive quality control program
- Fully accredited
- Complete billing service

ADVANCE MEDICAL &
RESEARCH CENTER, INC.

1270 Doris Rd • Pontiac, Michigan 48057
(313) 373-9120

Branches: Allen Park, East Jordan
Flint, Kalamazoo, Lansing, Pontiac

Serving the medical profession since 1963

MEETINGS

MSMS, MSMS/A, AMA medical assistants

Jan. 25, 1982 — MSMS/A Mid-Year Board meeting, MSMS Building, East Lansing, contact: Caroline Rich, MSMS headquarters.

Jan. 27, 1982 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 28-Feb. 11, 1982 — MSMS/INTRAV South American Adventure, contact: Marce Ireland, MSMS headquarters.

Jan. 30-31, 1982 — Medical Assistants Mid-Winter Seminar, Hyatt Regency, Dearborn, contact: Caroline Rich, MSMS headquarters.

Feb. 6-13, 1982 — MSMS/INTRAV West Indies Air/Sea Cruise, contact: Marce Ireland, MSMS headquarters.

March 7, 1982 — Medical Assistants Board Meeting, MSMS Building, East Lansing, contact: Caroline Rich, MSMS headquarters.

March 10, 1982 — MSMS Council Meeting, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

March 10, 1982 — MSMS/A Legislative Day, Civic Center, Lansing, contact: Caroline Rich, MSMS headquarters.

April 8, 1982 — MSMS Conference on Sports Medicine, Plymouth Hilton, contact: Mert Scholten, MSMS headquarters.

April 14-15, 1982 — 1982 Michigan Conference on Maternal and Perinatal Health, Grand Plaza Center, Grand Rapids, contact: Katie Brewbaker, MSMS headquarters.

April 30-May 1-2, 1982 — MSMS House of Delegates, Westin Hotel, Renaissance Center, Detroit, contact: Richard Campau, MSMS headquarters.

May 3-5, 1982 — 56th Annual Convention MSMS Auxiliary, Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

June, 1982 — AMAA Convention, Drake Hotel, Chicago, contact: Caroline Rich, MSMS headquarters.

Other meetings

Dec. 27 — Leadership Development Conference for Foreign Medical Graduates, in conjunction with the 14th Annual Convention of the Islamic Medical Association of North America and the First International Islamic Medical Congress, Sheraton Towers Hotel, Orlando, Florida, contact: American College of International Physicians, Inc., 3030 Lake Avenue, Suite 12, Fort Wayne, Indiana 219/424-7414.

Jan. 17-21, 1982 — 49th Annual Meeting of the National Association of Private Psychiatric Hospitals, "Challenges and New Realities for the Private Psychiatric Hospital," Marriott Camelback Inn, Scottsdale, Arizona, contact: NAPPH 202/393-6700, or NAPPH/Annual Meeting, 1319 F Street, NW, Suite 1000, Washington DC 20004.

April 5, 1982 — Wayne County Medical Society 61st Annual Beaumont Lecture, Bon Secours Hospital, Grosse Pointe, contact: Wayne County Medical Society.

Thanks to our advertisers

Advance Medical Research	679
Blue Cross/Blue Shield	653
Boyne, USA	654, 655
Brown Pharmaceuticals	677
Burroughs Wellcome	659
Carlton Lush Investments	650
CBC Labs	667
Eli Lilly	651
Infomax Systems	675
Insight at Colombiere	666
International Diamond	663
S.H. Kaplan Education Center	650
McCullagh Leasing	671
Medical Protective	679
Michigan Physicians Mutual Liability Company	669
MSMS Committee to Assist Impaired Physicians	668
National Medical Enterprises	644
Physicians Insurance Company of Michigan	657
Roche	642,643,644,IBC,BC
Stratton-Cheeseman	special insert
Troy Biologicals	670
US Army	665

COAL CO
COAL
JEFF KEATE

"Ed's prepared for the energy crisis."

CLASSIFIED

ositions open

RIME POSITIONS and prime practice loca-
ons now available throughout sunny Texas
or physicians in the following specialties: OB
YN,ENT, Internal Medicine, Urology, Or-
opedic Surgery, Radiology, Anesthesiology,
ediatrics and Family Practice. These practice
ocations are located in medium sized towns.
ost offer salary guarantee and free office rent
e first year. For further information, contact
enise Michaels, Director of Professional Rela-
ons, The Methodist Hospital Health Care Sys-
em, 6560 Fannin Street, Suite 1824, Houston,
exas 77030, (713) 790-6372.

ANTED — PRIMARY CARE physician
icensed in Indiana to practice in University
8-bed JCAH accredited hospital during
cademic year (approximately mid-August to
mid-May). Must be able to communicate with
nd have empathy toward the college age
opulation. Salary negotiable; excellent fringe
enefits. Send resume to T. A. Schott, Adminis-
rator, Purdue University Student Hospital,
West Lafayette, IN 47907. Equal Opportunity/
ffirmative Action employer.

HYSICIANS — if you are interested in relocat-
ng to "Big D," we have positions available in
nternal Medicine, Pediatrics, Family Practice,
nd Obstetrics/Gynecology. Respond with C.V.
o: Medical Director, INA Health Plan of Texas,
nc., PO Box 401828, Dallas, Texas 75240.

CHILD PSYCHIATRY Director and Chairper-
son. Excellent opportunity for a dynamic per-
son to direct the multi-disciplinary staff which
rovides a full range of services. The Child/
dolescent Psychiatry Department is a 40-bed,
short term, acute inpatient service and outpa-
ient clinic. Requirements for position: *Board
certified Child and/or Adult Psychiatrist *5
years' experience in residential or inpatient
treatment (3 of which have been with children)
*Strong administrative, clinical, teaching and
research skills *Active relationship with Pediat-
ric Department for provision of total child care.
Please send resume and salary history to Mr. LeRoy D. Fahle, Mount Carmel Mercy Hospital, 6071 West Outer Drive, Detroit, MI 48235. Mount Carmel Mercy Hospital (a member hospital of Sisters of Mercy Health Corporation) is a 597-bed teaching hospital located in a residential area of Northwest Detroit, An Equal Opportunity Employer M/F.

Second Obstetrician and General Surgeon wanted by 11 man multispecialty group in Northeastern Wisconsin. Reply to Gerard DeBruin, Business Manager, Boren Clinic, 1510 Main Street, Marinette, Wisconsin 54143.

PSYCHIATRIST — Full time staff psychiatrist position available in the Outpatient Mental Health Clinic. Responsibilities include outpatient treatment and student teaching. This is a 458 bed acute care facility located in suburban Detroit. Board certification preferred. Approximate salary range: low to mid-fifties. Liberal benefits offered. Send vitae to M. Roberts, MD, Director, Mental Health Service, Providence Hospital, 16001 W. Nine Mile Road, PO Box 2043, Southfield, Michigan 48037.

EIGHT MAN MULTI-SPECIALITY GROUP consisting of five family physicians seeking a board certified or board eligible Family Physician with a desire for obstetrics to join professional corporation serving a drawing population of 45,000. 200 bed hospital one mile from clinic. Excellent salary, variety of fringe benefits, and opportunity to become a partner after one year. Alpena located in Northern Michigan on a bay of Lake Huron and rates very high in outdoor recreation. Please send inquiries and C. V. to Barbara Barkley, Medical Arts Clinic, P.C., 211 Long Rapids Road, Alpena, MI 49707.

EMERGENCY MEDICAL POSITIONS — Emergency Consultants, Inc. has Emergency Medicine opportunities available in resort and metropolitan locations. 60 hospitals in 12 states are currently serviced. Benefits include competitive salaries, paid malpractice insurance, and flexible scheduling. For further information contact: Emergency Consultants, Inc., 2240 South Airport Road, Suite 115, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

OPHTHALMOLOGIST FULL-TIME, outstanding opportunity to join busy practice in suburb of Detroit. Reply to Box 20, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

CALIFORNIA-DIRECTOR POSITIONS AVAILABLE. Emergency medicine physicians needed for rural Northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit-sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610. 415/832-6400.

PART-TIME PHYSICIAN needed to do routine physicals to assess donor suitability for plasmapheresis. Good position for older physician looking to slow down. Malpractice coverage provided. Contact Thomas Anderson at American Plasma Management, Kalamazoo, MI. Phone 616/381-0086.

OPHTHALMOLOGIST WANTED to do office ophthalmology two or three days a week in well-equipped suburban office outside of Detroit. Excellent terms. Reply to Box 19, Michigan State Medical Society, 120 W. Saginaw, East Lansing, 48823.

Miscellaneous

FAMILY NURSE CLINICIAN seeks opportunity to work with a family physician in an office, clinic or HMO in the Midland, Bay City, Saginaw or Mt. Pleasant area. Three years experience in primary care. Currently completing research requirement for Master's in Nursing from MSU. Write or call Roxann Hamblin, R.N., B.S.N., 711 Kenny Ct., Midland, 48640, (517) 832-3692.

NORTHWESTERN MICHIGAN Intermediate Lake: Quality 4 bedroom home with finished walkout basement on 100' of prime sandy frontage, excellent for children. Home features cedar interior/exterior, stone fireplace to cathedral ceiling, sprinkler system to garden from lake, central air and much more. $130,000.00 with terms. Hood-Meeske Realty Company, PO Box 266, Bellaire, MI 49615-0266, (616) 533-6111.

NORTHWESTERN MICHIGAN. Torch Lake: 3 bedroom winterized home with 116 feet of frontage, features fireplace, decks and superb views of Torch Lake. Land contract or assumable mortgage. $69,900.00 Hood-Meeske Realty Company, PO Box 266, Bellaire, MI 49615-0266, (616) 533-6111.

NORTHWESTERN MICHIGAN. Magnificent home and setting on Grand Traverse Bay — 250 feet of private sandy beach plus ten wooded acres with stream. Architecturally designed new home overlooks Leelanau Peninsula. Oregon red cedar siding, Jacuzzi, steam sauna, Richmond Berber carpeting, stone fireplace, 3 baths, much more. $289,900.00. Terms. Hood-Meeske Realty Company, PO Box 266, Bellaire, MI 49615-0266, (616) 533-6111.

NORTHWESTERN MICHIGAN Gentleman Farm — This charming 2 story 4 bedroom home with formal living, dining and family rooms is graciously situated on 80 acres of apple orchard and hardwoods. A gentle sloping macadam circle drive ushers you around the willows to the stately main home, 2 story barn and guest/rental home. Make an appointment to view this well kept property near Alden. $145,000 with land contract terms. Hood-Meeske Realty Company, PO Box 266, Bellaire, MI 49615-0266, (616) 533-6111.

NORTHWESTERN MICHIGAN Estate Sale: 14 room brick home on over 200 feet of Torch Lake frontage includes 8 bedrooms, 6 baths, 3 fireplaces, basement with complete bar and game area, hot water heat, oak and maple floors and 3 car garage. Everything is in superb condition and the lot is beautifully landscaped and surrounded by mature evergreens. $195,000 with excellent terms. Hood-Meeske Realty Company, PO Box 266, Bellaire, MI 49615-0266, (616) 533-6111.

LAKE ANGELUS LAKE FRONT (Oakland County's most prestigious lake). Unique four year old architect-designed, custom-built redwood contemporary on approx. 140' lake frontage. 3 B.R., 2 bath. Approx. 2900 sq. ft. Oak hardwood floors. Custom oak cabinetry, built-ins and appliances. Abundant storage. Central air. Solid doors throughout. Wood-burning fireplace. Gourmet kitchen. Studio ceilings. Lake views from every room. 2 screened porches. Huge garage. Master B.R. suite with built-in king bed and 26' dresser. All watersports, no public access. Waterford schools. 20 minutes to Birmingham, W. Bloomfield or Troy. Includes 50' aluminum dock and 22' Viking Tri-hull with 260 h.p. Mercruiser. $365,000.00. By owner. (313) 963-0199 or (313) 674-3334.

PLATTE LAKE, Benzie County, Michigan, lake front residence, 6 rooms & bath, furnished, hot water heat, fireplace, space heater, garage, 4 wheel drive army truck, excellent beach, $65,000 on land contract. Additional frontage and adjoining 40 acres available. Call after 6:00 p.m., C. Koop, MD, 616-352-7971 or PO 666, Frankfort, MI 49635.

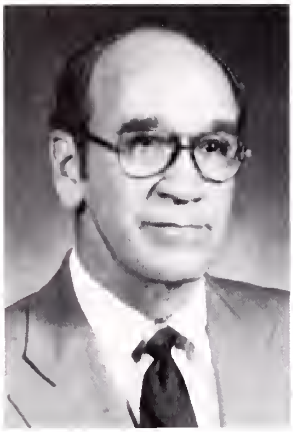
OFFICE PLANNING & DESIGN of the spaces and the systems which allow a medical practice to thrive. PSCrawford Associates offers professional assistance in developing programs for work flow and space utilization which incorporate efficient, humanistic design ambiance. Our services are structured to take your project from initial planning through completed installation. For a free Facilities Planning Checklist to aid you in defining your design needs call Pam Crawford at 313/665-5742 or write PSCrawford Associates, 116 E. Liberty, Ann Arbor 48104.

FOR SALE: Viagraph II Stress EKG testing unit, with treadmill. Contact Mr. Dlugokinski, of Flint Family Practice at 313-235-9803.

WE HAVE VARIOUS QUANTITIES OF MEDICAL EQUIPMENT available in excellent condition. We buy, sell, trade, move and repair. New equipment also available. Call Doctor Medical Resale, (313) 569-4407, 9 a.m. to 9 p.m.

SANDRA W. COCHRAN, MEDICAL ILLUSTRATOR. Medical illustration available, from detailed realistic renderings to simple diagrams, graphic design and biophotography. For quality illustrations at the lowest cost, call (313) 652-2547, or write 1163 Ironwood Court, Apt. 104, Rochester, Michigan 48063.

HILTON HEAD ISLAND, SC. Ocean Villa, Captain's Cove in Palmetto Dunes Resort. Luxurious new villa, 150 yds from beach. Lagoon backyard, 2 bedrooms, 2 baths, sleeps 6. Excellent golf, tennis, pool, fishing, canoeing, biking, etc. Weekly, monthly. Call or write, (313) 695-0356, 6236 Kings Crown Rd., Grand Blanc, MI 48439.



PRESIDENT'S PAGE

Medical society membership like a white coat

James D. Fryfogle, MD
MSMS President

An interview by the Editor with James D. Fryfogle, President of the Michigan State Medical Society.

Editor: Doctor Fryfogle, as President, we would like you to tell us what the medical society means to you.

JDF: You mean its structure, finance and programs?

Editor: No. What we want is what you feel about organized medicine. How does it affect you personally? Does it help make you a better doctor? Is it important to you?

JDF: Well, to me the medical society is like my white coat.

Editor: Your white coat!! What do you mean?

JDF: Well, my white coat is not something I wear all the time. I put it on when I'm being a doctor. It covers me and my actions. It protects me from spills and stains that happen during my work day. It gives me personal identification and allows passage through many doors that would say "no admission." Sometimes my white coat has my name on it, or OR, OB, or ER, or a hospital logo, thus making the identification more specific.

When I was a young doctor making house calls in an urban slum, my white coat was my professional badge. It protected my person and possessions, allowed me to do my job, with help and good wishes from the local citizenry.

And a white coat has lots of pockets, into which all manner of "doctor things" can be stuffed, such as my patient list, my schedule of meetings, my tools of the trade — stethoscope, flashlight, pen, EKG calipers, references to be looked up in the library for Journal Club meeting, and even my wife's shopping list.

When I've finished the surgical list and made final rounds, I hang up the white coat in the dressing room and am heartened to see other white coats missing from their hangers. It's good to know, as I change to street dress, that the white coats of other doctors will be caring for my patients while I'm gone.

The white coat is more than just a uniform. It represents a seriousness of purpose and authority that must be wisely used.

Once, in a hurry, I had to attend a board meeting in my white coat. The board was made up mostly of lay people. Although they knew I was a doctor, the white coat seemed to add to my powers of persuasion and we easily won our point.

Editor: You see the medical society in this simile?

JDF: Yes. While you're being a doctor, membership in these societies surrounds you, protects you, identifies you, gives you authority to act, speaks for you legislatively, politically and educationally. The Societies' many pockets are filled with doctor groups giving and getting information, holding the ethic high, and protecting freedom of choice and action in the doctor-patient relationships.

Also, when you revert to a non-medical role, it is good to know that other members of your Society are working to maintain your beliefs and values.

Editor: Is there anything else you want to say about medical societies?

JDF: Just this — If the white coat fits, wear it, and proudly!

1 16432

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

This Book is due on the last date stamped below. No further preliminary notice will be sent. Requests for renewals must be made on or before the date of expiration.

DUE	DUE

A fine of one dollar will be charged for each week or fraction of a week the book is retained without the Library's authorization.

INFORMATION CONSERVATION, INC.